SACHS J ABRIDGED JUDGMENT

Soobramoney v Minister of Health

[50] I am in full agreement with the eloquent, forceful, and well-focused judgment of Chaskalson P and wish merely to add certain considerations which I regard as relevant.

[51] The special attention given by section 27(3) to non-refusal of emergency medical treatment relates to the particular sense of shock to our notions of human solidarity occasioned by the turning away from hospital of people battered and bleeding or of those who fall victim to sudden and unexpected collapse. It provides reassurance to all members of society that accident and emergency departments will be available to deal with the unforeseeable catastrophes which could befall any person, anywhere and at any time. The values protected by section 27(3) would, accordingly, be undermined rather than reinforced by any unwarranted conflation of emergency and non-emergency treatment such as that argued for by the appellant.

[52] In a case such as the present which engages our compassion to the full, I feel it necessary to underline the fact that Chaskalson P's judgment, as I understand it, does not merely "toll the bell of lack of resources". In all the open and democratic societies based upon dignity, freedom, and equality with which I am familiar, the rationing of access to life-prolonging resources is regarded as integral to, rather than incompatible with, a human rights approach to health care.

[53] Indeed, while each claimant seeking access to public medical resources is entitled to individualised consideration, the lack of principled criteria for regulating such access could be more open to challenge than the existence and application of such criteria. As a UNESCO publication put it:

> "Even in the industrialized nations where public tax-supported research has made a private biomedical technology industry possible, the literal provision of equal access to high-technology care, utilized most often by the elderly, would

inevitably raise the level of spending to a point which would preclude investment in preventive care for the young, and maintenance care for working adults. That is why most national health systems do not offer, or severely ration (under a variety of disguises), expensive technological care such as renal dialysis or organ transplants."

The inescapable fact is that if governments were unable to confer any benefit on any person unless it conferred an identical benefit on all, the only viable option would be to confer no benefit on anybody.

[54] Health care rights by their very nature have to be considered not only in a traditional legal context structured around the ideas of human autonomy but in a new analytical framework based on the notion of human interdependence. A healthy life depends upon social interdependence: the quality of air, water, and sanitation which the state maintains for the public good; the quality of one's caring relationships, which are highly correlated to health; as well as the quality of health care and support furnished officially by medical institutions and provided informally by family, friends, and the community. As Minow put it:

"Interdependence is not a social ideal, but an inescapable fact; the scarcity of resources forces it on us. Who gets to use dialysis equipment? Who goes to the front of the line for the kidney transplant?"

Traditional rights analyses accordingly have to be adapted so as to take account of the special problems created by the need to provide a broad framework of constitutional principles governing the right of access to scarce resources and to adjudicate between competing rights bearers. When rights by their very nature are shared and inter-dependent, striking appropriate balances between the equally valid entitlements or expectations of a multitude of claimants should not be seen as imposing limits on those rights (which would then have to be justified in terms of section 36), but as defining the circumstances in which the rights may most fairly and effectively be enjoyed.

[55] I conclude with some observations on the questions raised relating to section 11 of the Constitution which states that "[e]veryone has the right to life." The present case does not

necessitate any attempt to give a definitive answer to all these questions. Yet it does point to the need to establish what Dworkin has in his book *Life's Dominion,* called the "relative importance of the natural and human contributions to the sanctity of life". He concludes his study with the eloquent reminder that if people are to

"retain the self consciousness and self respect that is the greatest achievement of our species, they will let neither science nor nature simply take its course, but will struggle to express, in the laws they make as citizens and the choices they make as people, the best understanding they can reach of why human life is sacred, and of the proper place of freedom in its dominion."

[56] "[T]he timing of death – once solely a matter of fate – is now increasingly becoming a matter of human choice." In the United States, eighty percent of the two million people who die each year, die in hospitals and long-term care institutions, and approximately seventy percent of those after a decision to forego life sustaining treatment has been made. The words of Brennan J of the US Supreme Court, writing in a different context, have resonance:

"Nearly every death involves a decision whether to undertake some medical procedure that could prolong the process of dying. Such decisions are difficult and personal. They must be made on the basis of individual values, informed by medical realities, yet within a framework governed by law. *The role of the courts is confined to defining that framework, delineating the ways in which government may and may not participate in such decisions.*" (My emphasis.)

[57] However the right to life may come to be defined in South Africa, there is in reality no meaningful way in which it can constitutionally be extended to encompass the right indefinitely to evade death. As Stevens J put it: dying is part of life, its completion rather than its opposite. We can, however, influence the manner in which we come to terms with our mortality. It is precisely here, where scarce artificial life-prolonging resources have to be called upon, that tragic medical choices have to be made.

[58] Courts are not the proper place to resolve the agonising personal and medical problems that underlie these choices. Important though our review functions are, there are areas

where institutional incapacity and appropriate constitutional modesty require us to be especially cautious. Our country's legal system simply "cannot replace the more intimate struggle that must be borne by the patient, those caring for the patient, and those who care about the patient." The provisions of the bill of rights should furthermore not be interpreted in a way which results in courts feeling themselves unduly pressurised by the fear of gambling with the lives of claimants into ordering hospitals to furnish the most expensive and improbable procedures, thereby diverting scarce medical resources and prejudicing the claims of others.

[59] The applicant in this case presented his claim in a most dignified manner and showed manifest appreciation for the situation of the many other persons in the same harsh circumstances as himself. If resources were co-extensive with compassion, I have no doubt as to what my decision would have been. Unfortunately, the resources are limited, and I can find no reason to interfere with the allocation undertaken by those better equipped than I to deal with the agonising choices that had to be made.