Palliative care for terminally ill inmates: Does the State have a legal obligation?

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ABSTRACT

'We ought to give those who are to leave life … the terminally ill … the same care and attention that we give those who enter life – the new-born.'[1] In this article it is contended that terminally ill inmates have a right to palliative care and that the State has a duty to fulfil this right. The number of unsuccessful medical parole applications and recorded natural deaths of inmates is considered as indicative of the problem of terminally ill inmates in South African prisons. It is further contended that the State's obligation arises from an inmate's constitutional right to health care and from an increasingly recognised international human right to palliative care.

1. Background

In the 21st century we have begun to recognise that our physical and mental well-being is fundamental to a dignified life. The endorsement of the right to health thus finds widespread support as a failure to give effect to it impairs the right to dignity. In South Africa efforts to fulfil the constitutional right to access health care services include *inter alia* free health care services for pregnant women and children under the age of seven years and the provision of Nevirapine to HIV-positive mothers and their new-born babies to prevent HIV transmission to babies.[2] However, the plight of inmates[3] who are terminally ill and denied release on medical parole[4] do not feature prominently on the State's health care agenda. They, like other terminally ill persons, need palliative care (which will be defined below).

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1 D Doyle , G Hanks, N Cherny, K Calman *Oxford Textbook of Palliative Medicine* 3ed (2004) 1199.

2 D McQuoid-Mason & M Dada *A –Z of Medical Law* (2011) 6. See also *Minister of Health v Treatment Action Campaign* 2002 (5) SA 721 (CC).

3 For the purpose of this paper 'inmate' refers to sentenced offenders in South African correctional centres.

4 'Parole' is '… a continuation of a sentence outside of the correctional facility.' J Mujuzi 'Unpacking the law and practice relating to parole in South Africa' (2011) 14 *PER* 205. 'Medical parole' is, in short, granted to an inmate who is too ill to continue serving his or her sentence in the correctional facility. In other words, an inmate can be released on humanitarian grounds.

It is argued here that the State has an obligation to provide palliative care to terminally ill inmates. This will be highlighted in discussions of the complexities presented by medical parole and the number of deaths in correctional centres. It is also contended that the State's obligation stems from an inmate's constitutional right to health care services and that it is further bolstered by an international human right to palliative care. In conclusion Uganda's approach to the provision of palliative care will be considered with a view to drawing on lessons for South Africa.

2. Why terminally ill inmates?

State funded palliative treatment is not readily available. Terminally ill persons who are not imprisoned may, with assistance from their family and support networks, gain access to *some* State services. They may also depend on their support networks where the State's assistance is lacking. The plight of inmates is worse. They cannot access services available to the public due to security measures in correctional centres, a lack of transport and staff capacity and the absence of family or other support networks. They are thus a marginalised group in the absence of state assistance.

3. Medical parole

When an inmate is diagnosed with a terminal disease, we expect that he or she will be released on medical parole. Due to the law which deals with medical parole, this is not always the case. Section 79 of the Correctional Services Act 111 of 1998 provides

> 'Any person serving any sentence in prison, and who based on the written evidence of the medical practitioner treating that person, is diagnosed as being in the final phase of any terminal disease or condition may be considered for placement under correctional supervision or on parole … to die a consolatory and dignified death.'

In *Du Plooy,* the Court emphasised that '… the general rule [is that] an offender cannot expect to escape punishment … because of ill health.'[5] Section 79 of the Correctional Services Act stipulates the circumstances under which inmates may be released on medical grounds. It has been amended, but the new provision is not yet in force (at the time of writing). The current law, section 79, will thus be discussed in addition to the new law.

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[5] *Du Plooy v Minister of Correctional Services* 2004 JOL 12850 (T) Case No. 6399/04 at para 4.

Section 79 permits the release of an inmate to allow a dignified and consolatory death. Consequently, inmates' state of health 'must have deteriorated to such an extent that their death is imminent.'[6] In *Stanfield*[7] the Court held '[t]o insist that he remain incarcerated until he has become visibly debilitated and bedridden can by no stretch of the imagination be regarded as humane treatment in accordance with his inherent dignity.'[8] The inmate suffered from incurable lung cancer and doctors certified that he had only months left to live, but he was denied medical parole by the Parole Board. The Court ordered the release of the inmate on medical grounds. In the subsequent case of *Mazibuko v Minister of Correctional Services*, the inmate was diagnosed with AIDS and his medical condition was deteriorating daily according to his doctors. The Regional Commissioner of Correctional Services, in Gauteng, however declined the inmate's application for parole. He then applied to the High Court to have the decision set aside. The Court ordered his release and held that to deny him medical parole was 'unjust, unlawful, unreasonable, and procedurally unfair.'[9] In *Du Plooy* the inmate was also diagnosed with AIDS. The Court held that not granting him medical parole was a 'violation of [his] right not be treated in a cruel, inhuman or degrading manner, and his right to access medical care, that it was in violation to human dignity, and that it was also irrational and unreasonable.'[10]

The above cases demonstrate that section 79 has sometimes been applied by parole boards in a manner that infringed upon inmates' right to dignity. There has also been controversy around the granting of parole in high profile cases. A case in point was the release on medical parole of Shabir Shaik, a businessman and former financial advisor of the South African president, Jacob Zuma. Mr Shaik had served less than three years of his fifteen-year sentence for fraud when he was released on medical grounds. The legitimacy of his release was the subject of debate in the media and has resulted in further controversy as he is still alive three years after his release.[11] It triggered interest in the issue of medical parole. A new law will, however, come into force soon. It is contained in section 14 of the Correctional Matters

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6 J Mujuzi 'Releasing terminally ill prisoners on medical parole in South Africa' *South African Journal of Bioethics and Law*, December 2009, Vol. 2, No. 2 at 59.

7 *Stanfield v Minister of Correctional Services* 2003 (4) All SA 282 (C).

8 Stanfield *v Minister of Correctional Services supra* (n 12) at para 124.

9 [2007] JOL 18957 (T) Case No. 3851/05, at 11.

10 *Du Plooy supra* (n5) at para 26.

11 See Mujuzi op cit (n6) 59. See also Mbonambi, G., and Khumalo, S. 'Shaik accused of attacking reporter', 28 February 2011, IOL News *http://www.iol.co.za/news/south-africa/kwazulu-natal/shaik-accused-of-attacking-reporter-1.1033213* [accessed on 1 October 2011].

Amendment Act 5 of 2011 and it substitutes section 79 in its entirety. Section 14 provides

'(1) Any sentenced offender may be considered for placement on medical parole, … if–

(a) such offender is suffering from a terminal disease or condition or if such offender is rendered physically incapacitated as a result of injury, disease or illness so as to severely limit daily activity or inmate self-care;

(b) the risk of re-offending is low; and

(c) there are appropriate arrangements for the inmate's supervision, care and treatment within the community to which the inmate is to be released.

(2) *(a)* An application for medical parole shall be lodged in the prescribed manner, by–

(i) a medical practitioner; or

(ii) a sentenced offender or a person acting on his or her behalf.

(b) An application lodged, by a sentenced offender or a person acting on his or her behalf, in accordance with paragraph (a)(ii), shall not be considered … if such application is not supported by a written medical report recommending placement on medical parole.

(c) The written medical report must include … .–

(i) a complete medical diagnosis and prognosis of the terminal illness or physical incapacity from which the sentenced offender suffers;

(ii) a statement by the medical practitioner indicating whether the offender is so physically incapacitated as to limit daily activity or inmate self-care; and

(iii) reasons as to why the placement on medical parole should be considered.

(3) *(a)* The Minister must establish a medical advisory board to provide an independent medical report to the National Commissioner, Correctional Supervision and Parole Board or the Minister, as the case may be. In addition to the medical report referred to in subsection (2)(c).

(b) Nothing in this section prohibits a medical practitioner or medical advisory board from obtaining a written medical report from a specialist medical practitioner.

(4) *(a)* The placement of a sentenced offender on medical parole must take place in accordance with the provisions of Chapter VI[12] and is subject to–

(i) the provision of informed consent by such offender to allow the disclosure of his or her medical information, to the extent necessary, in order to process an application for medical parole; and

(ii) the agreement by such offender to subject himself or herself to such monitoring conditions as set by the Correctional Supervision and Parole Board in terms of section 52,[13] with an understanding that such

[12] Chapter VI deals with community corrections. These are sentences that are served outside of correctional facilities.

[13] Section 52 sets out conditions relating community corrections. An offender can be ordered to, for example, seek employment, compensate the victim or take part in a development or support programme.

conditions may be amended and or supplemented depending on the improved medical condition of such offender.

(b) An offender placed on medical parole may be requested to undergo periodical medical examinations by a medical practitioner in the employ of the Department.

(5) When making a determination as contemplated in subsection (1)*(b)* the following factors, amongst others, may be considered:

(a) Whether, at the time of sentencing, the presiding officer was aware of the medical condition for which medical parole is sought in terms of this section;
(b) any sentencing remarks of the trial judge or magistrate;
(c) the type of offence and the length of the sentence outstanding;
(d) the previous criminal record of such offender: or
(e) any of the factors listed in section 42(2)(d).[14]

Section 14(2)(c)(ii) requires that an application for medical parole be supported by a written statement as to 'whether the offender is so physically incapacitated as to limit daily activity or inmate self-care.' The inmate must thus be helpless and dependent on others for care. This is similar to the 'final phase of the terminal illness' requirement in section 79.[15] In this respect the new provision seems constitutionally suspect as a requirement that an inmate should be bedridden and

[14] Section 42(2)(d) provides that a report must be submitted to the Correctional Supervision and Parole Board regarding –

(i) the offence or offences for which the sentenced offender is serving a term of incarceration together with the judgment on the merits and any remarks made by the court in question at the time of the imposition of sentence if made available to the Department;
(ii) the previous criminal record of such offender;
(iii) the conduct, disciplinary record, adaptation, training, aptitude, industry, physical and mental state of such offender;
(iv) the likelihood of a relapse into crime, the risk posed to the community and the manner in which this risk can be reduced;
(v) [a sentenced offender who has been declared a habitual criminal which indicates that–
(aa) there is a reasonable probability that such an offender will in future abstain from crime and lead a useful and industrious life; or
(bb) such an offender is no longer capable of engaging in crime; or
(cc) for any other reason, it is desirable to place such an offender on parole the assessment results and the progress with regard to the correctional sentence plan contemplated in section 38;
(vi) the possible [re-placement] placement of [such] an offender under correctional supervision in terms of a sentence provided for in section 276(1)(i) or 287(4)(a) of the Criminal Procedure Act, or in terms of the conversion of such an offender's sentence into correctional supervision under section 276A(3)(e)(ii), 286B(4)(h)(ii)] or 287(4)(h) of the said Act, and the conditions for such placement:
(vii) the possible placement of such sentenced offender on day parole [or on] parole or medical parole, and the conditions for such placement.

[15] *Stanfield v Minister of Correctional Services* supra (n7) at para 124.

visibly suffering in order to be released on medical parole infringes on his/her right to dignity.

In terms of section 14(1)(b) an inmate must pose a 'low risk of reoffending'. Section 14(4)(a) to (e) of the Act (see above) lists the factors to be considered in determining the risk. It is not evident how these factors can reasonably be regarded as indicators of an inmate's risk of re-offending. Past remarks by a sentencing judge and the nature of the offence the inmate had been convicted for, says nothing reasonably conclusive about future criminality. In *Stanfield,*[16] Van Zyl J held that '… it is irrelevant what the nature of [the offender's] conviction and the length of his sentence of imprisonment might be' when deciding whether or not a terminally ill inmate should be released.

Section 14 requires that appropriate arrangements be made for the inmate's care after release. The Act does not stipulate who is responsible for making these arrangements and what constitute 'adequate arrangements'. It also does not offer guidance as to what ought to happen if an inmate does not have a support structure in his or her community. This is despite the fact that the Department of Correctional Services has indicated to Parliament that there is a lack of 'after care by offenders' families, community structures and hospices [and] … [where] families were unable to take the inmate … into their care, the Department of Correctional Services simply took them back.'[17] The Legislature should have made it explicit that as custodian of inmates, the Department of Correctional Services will have to take steps to ensure the proper care of such inmates even outside prison walls.

In summary there are at least two categories of terminally ill inmates who require care. The first includes those who are not eligible for medical parole as they do not meet all the requirements of the medical parole provisions. The second category is those who have no support outside of the correctional environment and for whom the Department of Correctional Services cannot find alternative care in a hospice institutions for example.

4. Deaths in correctional centres

The Department of Correctional Services does not make available significant detail about the causes of death of inmates. The Judicial Inspectorate for Correctional Services' reports are therefore invaluable in gauging the extent to which inmates are affected by terminal illness. Below some of the most recent reports are discussed.

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[16] *Stanfield v Minister of Correctional Services supra* (n7) at para 82.

[17] *HIV Prevalence Survey, terminally ill inmates and medical parole issues*, 1 August 2008 http://www.openthesis.org/search/lastSearch.html [Accessed 7 August 2011].

The report for the period 1 April 2007 to 31 March 2008 indicated that 1136 inmates had died during 2007 and that 1056 of these fatalities were occasioned by natural causes.[18] The annual report for the period 1 April 2008 to 31 March 2009 showed that the Judicial Inspectorate for Correctional Centres had received 1048 death reports of which 982 were classified as natural deaths.[19] The Judicial Inspectorate for Correctional Services considers the classification of deaths as 'natural' or 'unnatural'. 'Natural' fatalities are dealt with internally by the Department of Correctional Services and are not subjected to an independent inquest in terms of section 2 of the Inquest Act 58 of 1959. Heads of Correctional Centres regard all deaths by natural causes such as heart attacks, strokes, cancer, tuberculosis and the like as 'natural'. No independent inquests are thus done in respect of such deaths.[20] This is problematic because a deceased who had suffered from a chronic condition, for example could have died as a direct result of an 'action' or 'inaction' by the Department of Correctional Services.[21] In early 2009 the Judicial Inspectorate for Correctional Services received a sample of 269 death reports. It appeared that 230 (86%) of the inmates had received medical treatment prior to their death. Medical parole was considered in 36 (14%) of these cases, but none of them had been successful. The Judicial Inspectorate concluded that this may be an indication that medical parole is not considered in the majority of cases in practice.[22]

The report for the period 1 April 2009 to 31 March 2010 indicates that medical officers do not substantively complete reporting forms in which the cause of death and underlying or contributory factors or pre-existing illnesses suffered by a detainee are recorded.[23] Many death certificates and supporting documentation related to natural deaths in 2009 did not reach the Judicial Inspectorate for Correctional Services before its annual report was made available, it was thus impossible to assess the circumstances under which the 992 reported deaths had occurred.[24] The 22,053 complaints about health care and 748 about medical parole received in 2009 must be considered to allude to unsatisfactory circumstances in the correctional centres.[25]

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[18] Judicial Inspectorate of Prisons Annual Report for the period 1 April 2007 to 31 March 2008 at 26.

[19] Judicial Inspectorate of Prisons Annual Report for the period 1 April 2008 to 31 March 2009 at 12.

[20] Judicial Inspectorate of Prisons *supra* (n19) at 24.

[21] Judicial Inspectorate of Prisons *supra* (n19) at 24.

[22] Judicial Inspectorate of Prisons *supra* (n19) at 25.

[23] Judicial Inspectorate of Prisons Annual Report for the period 1 April 2007 to 31 March 2008 at 27.

[24] Judicial Inspectorate of Prisons *supra* (n23) at 31.

[25] Judicial Inspectorate of Prisons *supra* (n23) at 37.

In summation, between 1 April 2007 and 31 March 2010 nearly 3000 inmates have died due to 'natural causes'. Though the number of fatalities during the three year period is arguably not high in proportion to the general inmate population, it is indicative that a problem exists and that the State should address the issue of terminally ill inmates.

5. The definition of palliative care

Before one may argue in favour of the right, it is necessary to understand the meaning of palliative care. Palliative care includes: physical; psychosocial; and spiritual care.[26] '[T]he essence of palliative care is the relief of pain.'[27] Palliative care aims to: (a) recognise the importance of life, but regards dying as a normal process; (b) provide relief from pain and other distressing symptoms; (c) integrate the psychological and spiritual aspects of patient care; (d) help patients live as actively as possible until death; and (e) assist the family to cope during the patient's illness and their subsequent bereavement when the patient dies;[28] (f) neither hasten or postpone death; (g) use a team approach to address the needs of patients and their families.[29] The World Health Organisation adds that palliative care is applicable early in the course of the illness.[30]

6. The state's obligation to provide palliative care to terminally ill inmates

The need for palliative care may be more evident than the right to palliative care. There is presently no specific law or national policy regulating palliative care.[31] The State's duty to provide palliative care to citizens can however be inferred from the right to health. This proposition will be discussed later. First, however, it will be explained why inmates enjoy the same rights as other citizens.

6.1 A constitutionally entrenched residuum of basic rights

The purpose of imprisonment is not to punish inmates.

> '[A] … prisoner retains all the basic rights and liberties … of an ordinary citizen except those taken away from him by law … or those necessarily inconsistent with the circumstances in which he, as a prisoner, is placed …

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[26] L Gwyther and J Cohen *Legal Aspects of Palliative Care* (2009) 2.

[27] Gwyther and Cohen op cit (n26) 2.

[28] McQuoid-Mason and Dada op cit (n2) at 312.

[29] Gwyther and Cohen op cit (n26) 2.

[30] Gwyther and Cohen op cit (n26) 2.

[31] McQuoid-Mason and Dada op cit (n2) at 312.

> [T]here is a substantial residuum of basic rights which he cannot be denied … .'[32]

The common law residuum principle was upheld in *Goldberg*. In *August*[33] where the Constitutional Court upheld inmates' right to vote in the elections, it confirmed that the principle had been 'reinforced and entrenched' by the Constitution.[34] Maseko and Singh correctly contend that '[p]risoners … enjoy those rights that are specifically provided to them by the Constitution [and] also that … enjoyed by ordinary people.'[35] The claim for palliative care may thus be premised on the constitutional right to health care services guaranteed in sections 27 and 35(2)(e), which are discussed next.

6.2 Section 27(1)(a): Everyone's right to have access health care services

Section 27(1)(a) requires that reasonable legislative and other measures be employed within the available State resources to ensure that the right is progressively realised. Section 27 was considered by the Court in *Soobramoney* where the applicant had sought expensive renal dialysis treatment from a State hospital to prolong his life. He was denied access because the hospital policy provided that the treatment was aimed at patients whose condition could be remedied.[36] The Court held that 'if everyone in the same position as the appellant was to be admitted, the [State's] carefully tailored programme would collapse and no one would benefit from that.'[37] There will be times when the State cannot focus on the specific needs of an individual and must adopt a holistic approach to the needs of the populace.[38] The appellant's claim was dismissed.

The claim for palliative care is distinguishable from that in *Soobramoney*. A claim for palliative care does not necessarily involve expensive treatment. The financial burden on the State will not be extended beyond the 'natural span' of a terminally ill person's life. Palliative care is aimed at upholding the dignity of a dying person. The contention here is not that state-of-the-art treatment should be provided instantly, but that there should be a plan to address basic needs of

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[32] *Goldberg v Minister of Prisons* 1979 (1) SA 14 (A) at 39D-F.

[33] *August v Electoral Commissions* 1999 (3) SA 1 (CC).

[34] *August supra* (n33) at paras 18-19.

[35] A Singh and TW Maseko 'The protection of prisoners' rights to health care services in the South African law: Is it adequate?' (2006) 31 *Journal for Juridical Science* 80 at 81.

[36] *Soobramoney v Minister of Health (Kwazulu-Natal)* 1998 (1) SA 765 (CC) at para 1.

[37] *Soobramoney supra* (n36) para 26.

[38] *Soobramoney supra* (n36) para 31.

terminally ill persons and which sets out how comprehensive care will be afforded in the long-term.

6.3 Section 35(2)(e): Right to appropriate conditions of detention

> 'Every sentenced person has a right to conditions of detention that are consistent with human dignity, including at least … the provision at State expense of adequate … medical treatment.'

Section 35(2)(e) of the Constitution is not subject to resource limitation. A 'strong constitutional protection afforded to the socio-economic rights of [inmates] is appropriate given [that] inmates are totally dependent on the state for all their basic needs'.[39] A claim for palliative care may thus be premised on section 35(2)(e). It will be seen below that there is 'some discord' between the High Court's interpretation of the provision in *Van Biljon* and how scholars have construed it. [40]

In *Van Biljon*[41] the Court ordered that HIV-positive inmates should be provided access to antiretroviral treatment. It held that 'once it is established that anything less than a particular form of medical treatment would not be adequate, the prisoner has a constitutional right to that treatment.'[42] The Court read resource qualification[43] into the ambit of the right by adding that adequate medical treatment must be considered within the scope of what the State can afford.

Maseko and Singh contend that the standard of adequacy in section 35(2)(e) should not have been made subject to the availability of resources.[44] The 'accepted basic standards of medical treatment for prisoners in international and comparative law'[45] should have been considered. Furthermore, the Court should have considered the fundamental rule that inmates must be treated with humanity and that their dignity must be respected. They emphasise the African Commission's decision in *Mukong v Cameroon*[46] where it was held that the fulfilment of prisoners' right to health care, as a requirement in terms of the Standard Minimum Rules for the Treatment of Prisoners,

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[39] See S Liebenberg *Socio-Economic Rights: Adjudication under a Transformative Constitution* (2010) 257.

[40] M Pieterse 'The potential of socio-economic rights litigation for the achievement of social justice: Considering the example of access to medical care in South African prisons' (2006) 50 *Journal of African Law* 118 at 125.

[41] *Van Biljon v Minister of Correctional Services* 1997 (6) BCLR 789 (C).

[42] *Van Biljon supra* (n41) at para 49.

[43] J Barnes 'Not too 'great expectations': Considering the right to health care in prisons and its constitutional implementation' (2009) *SACJ* 39 at 44.

[44] Singh and Maseko op cit (n35) 90.

[45] Singh and Maseko op cit (n35) 90.

[46] No.458/1991 (August 10, 1994) U.N. Doc.CCPR/C/51/D/458/1991.

does not depend on the availability of resources. It means that the availability or lack of resources should determine the nature of the actions to be taken by a State. If the fulfilment of a right thus requires substantial resources which the State does not have at its disposal, the State must still take steps in pursuance of the right. The initial steps may involve actions which require limited resources.

With regards to unqualified rights like section 35(2)(e), resource limitations should not be applied to the ambit of the entitlement, but rather to the enforcement of the right.[47] A limitation will then have to be justified in terms of section 36 of the Constitution.[48] Given the strict criteria of section 36 it ought not to be easy for the State to justify a refusal to provide palliative care.

Liebenberg states that the words 'at least' in section 35(2)(e) denote the minimum goods and services which inmates should be afforded.[49] Inmates may claim 'whatever [is] necessary to ensure conditions of detention consistent with human dignity'. This interpretation has been borne out by a number of cases subsequent to *Van Biljon*. In *Strydom*[50] the Court held that the prison authority's decision to remove access to electrical sockets in the prison cells was a violation of the inmates' human dignity.[51] The Court ordered that inmates be given access to electricity in their cells. In *N*,[52] fifteen HIV/AIDS positive inmates sought an order compelling the State to *inter alia* give them access to anti-retroviral treatment in accordance with the government Operational Plan for Comprehensive HIV and AIDS Care (Operation Plan). The Court held that it was 'regrettable that prisoners, being a class, very vulnerable to infection, were not given special consideration in the Operational Plan … .'[53] It was ordered that inmates be granted access to the programme. A reasonable State programme must therefore debatably include vulnerable groups like inmates. In *Ehrlich v Minister of Correctional Services,* the Court held that the prison authority's decision to prohibit the applicant's access to the prison gymnasium where their karate development programme had been running for the previous two years violated the inmates'

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47 Pieterse op cit (n40) 125. See also Liebenberg op cit (n39) 258.

48 Pieterse op cit (n40) 126.

49 See Liebenberg op cit (n39) 257. *Huang v Head of Grootvlei Prison* Case No 992/2003 (ZAFSHC) (unreported judgment of 15 May 2003) at para 30.

50 *Strydom v Minister of Correctional Services* 1999 (3) BCLR 342 (W).

51 *Strydom supra* (n50) at para 15.

52 *EN and Others v Government of the RSA and Others* [2007] 1 All SA 74 (D).

53 *N supra* (n52) at para 29.

right to dignity.[54] The Court ordered that access to the gymnasium be allowed.

These cases demonstrate that the State's obligation may involve enabling access to the resources in the correctional centres as well resources provided to the public. The State may follow this approach in giving effect to terminally ill inmates' rights.

6.4 An emerging international human right to palliative care

There is a growing recognition of an international human right to palliative care.[55] International law does not expressly provide for a right, yet advocates for palliative care contend that it can be successfully argued for. Various international law instruments will be discussed below.

The World Health Organisation's definition of 'health' and 'palliative care' gives rise to a reasonable inference that health applies to all including people with life-limiting illnesses.[56] Palliative care forms part of a continuum of health care for all persons. According to Brennan, a right to palliative care may thus be implied from the overall international human right to health.[57] Given that it includes more than 'medical care' the right to palliative care is also indirectly supported by other rights such as the right to food, accommodation, social security and importantly, the right to dignity.

6.4.1 The Universal Declaration of Human Rights

The Universal Declaration of Human Rights[58] prohibits 'cruel, inhuman or degrading treatment'.[59] A failure to afford necessary palliative care to inmates, especially treatment aimed at alleviating pain, may be challenged as a violation of the right. Furthermore, the Declaration states that '[e]veryone has the right to a standard of living adequate for the health of himself and his family, including food, clothing, housing and medical care and necessary social services.'[60] Arguably this formulation promotes the holistic approach which palliative care affords patients.

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[54] *Ehrlich v Minister of Correctional Services and Another* 2009 (2) SA 373 (E) at para 43.

[55] See the Cape Town Declaration (2002), the Korea Declaration (2007) and the Budapest Commitment (2007).

[56] F Brennan 'Palliative care as an international human right' (2007) 33 *Journal of Pain and Symptom Management* 494 at 495.

[57] Brennan op cit (n56) 495.

[58] Universal Declaration of Human Rights, GA Res 217 A (III) (10 December 1948).

[59] Article 5.

[60] Article 25.1.

6.4.2 International Covenant on Civil and Political Rights (1966)

The Human Rights Committee on Civil and Political Rights has held that the conditions of detention and treatment of inmates may, in certain circumstances violate article 7 which prohibits cruel, inhuman and degrading treatment.[61] States parties are under an obligation, 'regardless of their development', to comply with certain minimum standards regarding the conditions of detention. These include *inter alia* adequate sanitary facilities, clothing, food of nutritional value, adequate for health and strength.[62] The minimum standards must be complied with even under conditions of budgetary constraints.[63] The Covenant in article 10 places a positive duty on the States parties to ensure that inmates are treated with respect and human dignity.

6.4.3 International Covenant on Economic, Social and Cultural Rights

The International Covenant on Economic, Social and Cultural Rights,[64] signed by South Africa, provides that '[t]he State Parties … recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'[65] The International Covenant on Economic, Social and Cultural Rights Committee has interpreted the right to health as

> 'an inclusive right extending … to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, and adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions and access to health-related education and information … .'[66]

The Covenant recognises that rights may not be immediately attainable due to resource-constraints. State parties are thus committed to progressive realisation of the right to health. The Committee recognises that the right is dependent upon a number of social, economic and cultural rights and while this raises challenges of how to prioritise

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61 Liebenberg op cit (n39) 259.

62 *Allen Womah v Cameroon,* Comm No 458/1991, Report on Human Rights Committee, Vol II, General Assembly Official Records, 49th Sess Suppl No 40 (A/49/40) para 9.4.

63 *Allen Womah supra* (n62) para 9.4.

64 International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966).

65 Article 12.1.

66 The Right to the Highest Attainable Standard of Health, UN Committee on Economic Social and Cultural Rights General Comment No 14, UN Doc E/C/12/2000/4 para 38.

an entire population's socio-economic needs, it must be accepted that rights are interdependent.[67]

The International Covenant on Economic, Social and Cultural Rights Committee has confirmed that access to essential drugs, as defined by the World Health Organisation Action Programme on Drugs, is part of the minimum core content of the right to health. At least fourteen palliative care medications are on the World Health Organisation Essential Drug List.[68] The Committee has observed that a State party '… cannot … justify its non-compliance with the core obligations … which are non-derogable'.[69] In General Comment No 14 issued by the Committee it is asserted that State parties must respect the right to health by refraining from denying or limiting equal access for all persons, including prisoners to preventative, curative and palliative health services. It is significant that palliative care is recognised as a health service alongside curative and preventative care. It denotes that these health services are all of equal importance.

The United Nations Special Rapporteur on torture and other cruel, inhuman and degrading treatment or punishment reported that the *de facto* denial of access to pain relief, 'if it causes severe pain and suffering, constitutes cruel, inhuman or degrading treatment or punishment.'[70] He recommended that 'all measures should be taken to ensure full access and to overcome regulatory, educational and attitudinal obstacles to ensure full access to palliative care.'[71]

6.4.4 International instruments pertaining to inmates

A detailed discussion regarding international instruments that apply to inmates' health rights in South Africa is beyond the scope of this paper. Instruments providing for inmates' right to health care services include: The Standard Minimum Rules for the Treatment of Prisoners (1955); The Basic Principles for the Treatment of Prisoners (1990); Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (1988) and the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (1990). The

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67 In *Government of the Republic of South Africa v Grootboom* 2001 (1) SA 46 (CC) at para 23 the Court held that all rights in the Bill of Rights are inter-related and mutually supportive.

68 Gwyther and Cohen op cit (n26) 9.

69 D Lohman, R Schleifer, J Amon 'Access to pain treatment as a human right' (2010) 8 *BCM Medicine* 1 at 6.

70 M Nowak 'Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Promotion and Protection of all Human Rights, Civil, Political, Economic, Social and Cultural Rights, including the right to development' A/HRC/10/44, 14 January 2009 at para 72.

71 Nowak op cit (n70) at para 74.

African Commission Robben Island Guidelines[72] are also important as they prohibit torture, cruel, inhuman and degrading treatment. These provide that States must ensure that detainees are treated in conformity with the international standards guided by the United Nations Standard Minimum Rules for the Treatment of Prisoners.[73] The latter instrument contains standards for the nature of medical services to be provided to prisoners, as well as the conditions of their detention, including facilities, food, sanitation and exercise. It also provides that inmates who require specialised treatment should be transferred to facilities where their needs can be met.[74] This strengthens the claim of terminally ill inmates.

The notion of palliative care as an international human right enjoys increasing support, yet at least one alternative to framing the right in this way has been proposed. Kirk argues that the claim is not sufficiently developed philosophically.[75] He suggests that the right to palliative care can be reasonably grounded in the 'sanctity of individual liberty'.[76] 'Pain … [is] an incursion on liberty … .'[77] He argues that States must introduce national palliative care strategies that maximise opportunities for effective care that minimises pain and provides individual liberty. Additionally, Kirk argues that human rights are perceived as individually held rights, while palliative care is aimed at palliating the suffering of terminally ill patients and their relatives. He advises that palliative care ought to be framed as a collective right.[78]

Kirk's argument *can* give impetus to the promotion of palliative care services. It must be contended, however, that to frame palliative care as a human right is not ineffective as he suggests. Though couched as an individual human right in many international instruments, the right to health when given effect to has a positive impact on the well-being of both the individual and his/her intimates. Arguably, care provided to the patient not only consoles those close to him/her, but it also affirms to them that their rights will be given effect to. Colombo and Ziegler appropriately state '… what most of us fear the most of death, is not so much the fact that we will not be around anymore, but rather the possibility of becoming, before dying, an intolerable burden, for

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[72] Guidelines and Measures for the Prohibition and Prevention of Torture, Cruel, Inhuman or Degrading Treatment or Punishment in Africa.

[73] Article 3.

[74] See rules 22-23 of the instrument. See also Liebenberg op cit (n 37) 258.

[75] T Kirk 'The meaning, limitations and possibilities of making palliative care a public health priority by declaring it a human right (2011) 4 *Public Health Ethics* 84.

[76] Kirk op cit (n75) 87.

[77] Kirk op cit (n75) 87.

[78] Kirk op cit (n75) 89.

ourselves and for others.'[79] The human rights approach to palliative care speaks to the concerns of the individual and the collective.

It is contended that there is an unspoken acceptance that satisfying the individual rights of a terminally ill patient eases the suffering of those around the patient. There is thus a collective benefit flowing from the fulfilment of an individual human right. Moreover it strengthens the claims of others in similar positions.

7. Uganda

In 1998 the Ugandan government and the World Health Organisation agreed that national palliative care policies must be developed, that training in palliative care and access to drugs will be increased.[80] Subsequently, Uganda became the first nation in Africa to declare palliative care an essential clinical service for all citizens.[81] Uganda's efforts should be a motivation to South Africa. The Ugandan Constitution does not contain a substantive right to health care, but under its national objectives of national policies it requires that the State 'take all practical measures to ensure the provision of basic medical services to the population'.[82] Mubangizi and Twinomugisha explain that Uganda is State party to many international and regional human rights instruments that spell out the right to health care and further that the Ugandan Constitution provides that the rights and freedoms specifically mentioned in the Bill of Rights do not exclude other rights not mentioned.[83] The right to health must thus be given effect to. To this end the introduction of policies set the 'level of health care guaranteed'. Though Uganda still has much to do to meet the full extent of its obligation, the country is moving in the right direction.[84]

8. Conclusion

The time is ripe to recognise that not all terminally ill inmates are released from correctional centres. In the past some inmates have

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79 S Colombo and R Ziegler 'End-of-life and the good society: Affirming a legal right to palliative care – A model for Israel' (2001) 2 *European Journal of Comparative Law* 287 at 295–296 .

80 Lohman *et al* op cit (n69) at 7.

81 Lohman *et al* op cit (n69) at 7.

82 J Mubangizi and B Twinomugisha 'The right to health in the specific context of access to HIV/AIDS medicines: What can South Africa and Uganda learn from each other?' (2010) 10 *African Human Rights Law Journal* at 105.

83 Mubangizi and Twinomugisha op cit (n82) at 122.

84 T Bwambale, V Nabaranzi 'Only 10 % Ugandans have access to palliative care' *New Vision* 2 September 2011, available at http://www.newvision.co.ug/D/8/16/764124 [accessed on 3 September 2007].

been denied release on medical parole even in instances where they had been diagnosed with a terminal illness. The case law as well as the statistics on medical parole and natural deaths of inmates provided by the Judicial Inspectorate attests to this reality. Additionally, the Department of Correctional Services has confirmed that it has in its custody terminally inmates who do not have any support networks outside of prison and who can thus not be released. The problem of terminally ill inmates who require palliative care thus beckons an urgent need for State action. Moreover the State must recognise that it has a legal obligation to provide terminally ill inmates with palliative care. The State's duty arises from inmates' constitutional right to health care services in terms of both section 27 and section 35(2)(e). Section 35(2)(e) in particular affords inmates the right to claim medical treatment and other services that will at least give effect to their human dignity. A successful claim for palliative care on this basis is highly possible. It is also bolstered by the growing recognition of an international human right to palliative care which applies to everyone including inmates.