Department Criminal and Procedural Law

MEDICAL LAW

Only study guide for
LCR4802

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Pretoria
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Introduction

General

We would like to welcome you as student of the module Medical Law. We trust that you will find the module interesting, stimulating and informative. It is important to read this introduction before you proceed with your study.

The nature of this module

Of all the professions none is more intimately involved with the law than the medical profession. Protecting man, his life, personality, physical integrity, health, honour and dignity is one of the fundamental objects of the law. Since medical science is concerned with man’s life, health and personality, the medical profession has a direct interest in the law. Medical science depends in no small degree on the law in order to create an atmosphere conducive to practice, research and advancement, and it calls on the law to determine the permissible limits within which it may operate.

In turn, the law is closely affected by developments in the field of medical science. Medical science is often of surpassing importance where legal facts such as birth, mental abnormality, death, paternity, and intoxication need to be proved in the course of the administration of justice.

The branch of medical science concerned with the study of juridically relevant facts is known as forensic medicine. It plays a vital role in modern society and is taught in medical faculties. In certain law faculties students also receive tuition in the fundamentals of the subject.

What is forensic science? This expression is used as an umbrella term covering the entire discipline concerned with the establishing and proving of juridically relevant scientific facts in a court of law. Forensic science therefore includes the science of identifying persons (by means of fingerprints, vocal frequencies, and other physical characteristics), ballistics (identification of bullets), graphology, forensic psychiatry and, of course, forensic medicine. Forensic medicine is offered as a separate module by this University. Forensic psychiatry is also of great importance in our time; it is alluded to in Criminal Law in the discussion of the defence of criminal incapacity.

Medical law is that branch of the law which is concerned with the study of the legal provisions relating to the practice of medicine and of health-care professions in general.

There are numerous points of common interest between forensic medicine and medical law, but the two disciplines differ in principle. Forensic medicine belongs to the natural sciences whereas medical law is a juristic discipline. For example, the law will lay down the rules on what is punishable as abortion, while forensic medicine will investigate the scientific aspect of alleged acts of abortion, explain it, and submit the facts to the court.

In this module we concentrate on important aspects of medical law. Since it is not possible to cover the entire field due to its vast scope, we are compelled to work selectively.
The law stated in this study guide is as it was on 30 November 2011. Some parts have been updated to reflect a more recent position.

The outcomes of this module

The outcomes of this module:

- Identify and understand the role of medical and health-care law in current South African law and everyday life, affecting millions of people.
- Demonstrate an understanding of the history and theoretical framework of, and the most pressing and prevalent issues regarding the law relating to medical practice (including the health-care professions in general and hospital services in both the public and private sector).
- Apply the principles of medical law in practical situations and solve multi-dimensional legal problems associated with health-care and hospital practice.
- Conduct research.

The value of this module

Today medical law is undoubtedly one of the most dynamic branches of the law. Its origins are very old. The earliest reference to possible legal liability of physicians is to be found in the great code of Hammurabi, King of Babylonia, in the second millennium BC. There are also numerous references to be found in Roman-law sources.

Medical science did not evolve in a vacuum, and medicine cannot be practised in a vacuum, figuratively speaking. The healing science is directed in principle to serve the interests of human beings, society in other words, and is practised in a world governed by religious beliefs, ethical codes and legal systems.

These value systems have always played a role in protecting the public against well-intended but occasionally dubious activities of scientists for example bent upon projects of social engineering or scientific experimentation.

The evolution of medical science was a relatively slow process of trial and error until the late 19th century. Since approximately the middle of the 20th century its evolution has been increasingly rapid and nothing short of miraculous. By the beginning of the 21st century procedures which not so long ago were regarded as science fiction or were not even dreamt of, have become commonplace. In addition the range of highly effective forms of medication has expanded beyond all recognition. There have been spectacular advancements in respect of human genetics, for example. However, genetic manipulation has raised ethical and legal problems to which we do not yet have final answers.

Yet new problems or forms of disease for which medical science seems unable to offer a cure appear in society from time to time. The prime example of our time is AIDS (the acquired immunodeficiency syndrome) which has mowed down millions of people during the last three decades and for which medicine has not yet produced a cure.

The purpose of this module is to equip you with knowledge of and insight into the law pertaining to the medical and health-care professions (including hospital practice) and basic research skills in the practice of law.
Many of these principles are of direct practical use. In respect of some of the most modern innovations we are not yet able to give final answers to the concomitant ethical and legal issues, but we hope to make you at least aware of what the answer or possible answers might be. Above all we have set out to stimulate your interest so that you may think independently about these issues. Medical law is an extremely dynamic and interesting subject!

Terminology

The law governs practically every aspect of human activity. In order to be a good lawyer, you would have to take cognisance of other fields of human activity, in other words to familiarise yourself with other fields of knowledge. If, for instance, you have to question or cross-examine an expert in a particular field in court, you will have to do your homework to enable you to put relevant questions to the expert, and to identify and expose weaknesses in the evidence.

Medical law offers an excellent opportunity for broadening your horizons. It is, to a large extent, an applied science in the sense that a variety rules from a wide variety of legal disciplines affect the medical profession. A doctor may incur liability in delict (law of delict) or in contract (law of contract). Medical practitioners might commit an offence in the course of professional practice (criminal law). Many of the subjects in the law curriculum cover one legal discipline only. The practical reality is that legal problems do not present themselves neatly confined to a particular legal discipline. Legal problems are often complicated and require you to unravel a tangle of facts, to identify and solve all the legal problems pertaining to different legal disciplines. Where you are unable to solve all the problems, an expert should be called in.

Apart from legal disciplines, medical law involves the field of medicine. It is impossible to study medical law without taking cognisance of medical facts. We do not intend to equip you with an in-depth knowledge of medicine. We realise that for many of you this might be the first formal encounter with the field of health care and medicine. It offers you a wonderful opportunity to acquaint yourself with a fascinating and completely new field of knowledge at a level that is not at all intimidating. To provide you with a key to this new field of knowledge we have included a glossary of terms at the end of each study unit. You should find it very interesting. All the terms that appear in the glossary are indicated in the text in red. When you come across an unfamiliar term while reading the study material, turn to the glossary at the end of the particular study unit. The glossaries are included for explanatory purposes only and are intended to facilitate comprehension of the contents of the study guide. You do not have to learn all the terms by heart. The glossaries may be particularly helpful when doing revision. Since the terms are arranged alphabetically, and not according to theme, it would be beneficial to work through the entire list. When you come across a term in the glossary, try to recall the context in which it cropped up in the text and the legal principles involved.

Format of the study guide

This study guide comprises a 11 study units, each dealing with a particular aspect of medical law. It is important to note that parts of some study units contain material which was inserted for general background reading only and need not be studied for examination purposes. We shall draw your attention specifically to these parts.
Format of a study unit

Each study unit is presented as follows:

- a table of contents (in blue) of the material discussed in the study unit
- a list of desired outcomes (in black) you should bear in mind when studying the study unit
- an exposition of the topic covered in the study unit
- activities
- feedback
- a glossary

Colour coding

In this study guide we make use of colour coding.

- **Headings, tables of content, and cross-references appear in blue**
- **Text and learning outcomes appear in black**
- **Activities incorporated in the text appear in a green block with a question mark. Green lines appear on either side of the activities at the end of a study unit**
- **Feedback on activities incorporated in the text, as well as practical examples, appear in a purple block. Purple lines appear on either side of the feedback on activities at the end of a study unit**
- **Terms included in the glossary appear in the text in red**
- **Useful hints appear in orange**
- **The names of cases are highlighted in yellow**

Prescribed cases

We refer to many cases in this study guide and sometimes we discuss a case in detail. In the latter instance you should ensure that you know and understand the facts of the case and the essence of the point or points of law decided in the case. Regard these cases as of major importance. At other times we cite cases merely by way of the source of authority for our discussion.

Time permitting, it is always helpful to look up cases in the law reports and to read them, but for examination purposes you may study only the discussion of these cases in the study guide.

Activities and feedback

You will find activities both incorporated in the discussions and at the end of each study unit. The activities at the end of a study unit are followed by feedback in which you receive guidance on furnishing the correct answer. Each activity should be regarded as an assignment for a particular study unit. The feedback will enable you to evaluate your answer. Feedback is not provided on all the activities incorporated in the text. These activities are intended to stimulate interest and elicit debate.
Conclusion

At the end of the semester for which you are registered you will write an examination. The purpose of your study should not only be to pass the examination, but to be able to apply the knowledge you have gained to situations that you may encounter in practice. We wish you every success with your studies.

LC Coetzee and L Pienaar

Mrs Pienaar and Adv Coetzee
STUDY UNIT 1
The Constitution and medical law

Contents
1.1 Introduction
1.2 The prohibition of unfair discrimination
1.3 The right to life
1.4 The right to freedom and security of the person
1.5 The right to privacy
1.6 The right to health care
1.7 The rights of children
1.8 The right to information
1.9 The right to just administrative action
1.10 The rights of prisoners

Activities
Feedback
Glossary

Learning outcomes
When you have completed this study unit, you should be able to

- identify the constitutional provisions relating to each of the values or special groups of persons listed above
- discuss the most important interpretations of the relevant constitutional provisions by the courts

1.1 Introduction

In our constitutional dispensation all law is subject to the provisions of the Constitution, 1996. A significant number of the provisions of the Bill of Rights may come into play in various situations pertaining to medical law. In this brief study unit these provisions come under scrutiny. This study unit therefore does not cover a specific subject, as is the case in most of the other study units, but rather provides a constitutional “backbone” that you have to keep in mind when studying the rest of the study guide. As this discussion covers specific constitutional rights and not a specific subject, you are at the outset introduced to a number of situations and problems pertaining to medical law. You can also expect to be asked to return to this study unit regularly while studying the other study
units. Throughout you should consider other medical and health matters where the Bill of Rights may have an impact, and enjoy this first glimpse of the fascinating and stimulating subjects which are covered in this study guide!

1.2 The prohibition of unfair discrimination

Section 9 of the Constitution deals with equality. In terms of this section everyone is equal before the law, and everyone has the right to equal protection and benefit of the law. Unfair discrimination on certain grounds, *inter alia* the ground of disability, is prohibited. Discrimination on the ground of disability is unfair unless it is established that it is fair. Depending on the final interpretation of this provision by the Constitutional Court, this provision may be relied upon, for example by someone with epilepsy challenging discrimination in respect of employment.

The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 gave effect to section 9. This Act contains a comprehensive list of grounds on which discrimination is prohibited. One of these is disability. Section 9 of the latter Act prohibits discrimination on the ground of disability, including

- denying a disabled person any supporting facility necessary for his or her functioning in society
- contravening the code of practice of the South African Bureau of Standards that govern environmental accessibility
- failing to eliminate obstacles that unfairly limit or restrict persons with disabilities from enjoying equal opportunities

Section 34 of Act 4 of 2000 states that there is “overwhelming evidence” of the impact of HIV/AIDS on society and the prejudice and discrimination against people on this ground, and therefore compels the authorities to consider additional measures in this regard. The courts are, however, empowered to decide that HIV/AIDS is a prohibited ground of discrimination.

The Schedule to Act 4 of 2000 contains a list of examples of unfair practices in the health care sector, such as:

- subjecting persons to medical experiments without their informed consent
- unfairly denying or refusing any person access to healthcare facilities or failing to make health care facilities accessible to any person
- refusing to provide emergency medical treatment to persons of particular groups identified by one or more of the prohibited grounds
- refusing to provide reasonable health services to the elderly

From a study of the Act read with the Bill of Rights it is clear, however, that there is no duty upon private practitioners or hospitals to give access to these facilities or render these services free of charge.

Unfair discrimination is however not solely prohibited to protect patients. In terms of the National Health Act 61 of 2003 (s 20) unfair discrimination against health care personnel on the grounds of their health status is also prohibited (see 3.16 below).

1.3 The right to life

Section 11 of the Constitution provides that everyone has the right to life. This right has been protected by common law since the earliest times, and the constitutional provision serves to strengthen it.

Abortion (which will be discussed in 8.2) is a subject where the right to life may not be ignored. In Christian Lawyers Association of SA v Minister of Health 1998 (4) SA 1113 (T) a provincial court ruled that the Choice on Termination of Pregnancy Act 92 of 1996, governing abortion, was not in conflict with the constitutional right to life. The Act was challenged on the ground that it allows the termination of human life. It was contended that section 11 of the Constitution applied also to unborn children from the moment of conception. The court, however, held that the word “everyone” does not include a foetus.

Naude T “The value of life: a note on Christian Lawyers Association of SA v Minister of Health” 1999 SAJHR 541 criticises this finding. She convincingly argues that an investigation into the constitutionality of the Act may not be reduced to the question whether the foetus is vested with the right to life. The state has a duty to promote the right to life, and to her mind that means that the state probably has a justiciable duty to enact legislation which properly protects foetal life. Slabbert MN The human embryo and foetus: constitutional and other legal issues (unpublished LLD thesis, Unisa, 2000) 337–338 argues that the duty of the state to ensure that human life is respected and valued – in other words, the duty to promote the so-called “sanctity of life” – also relates to developing human life. To her mind it is not impossible that some of the provisions of the Choice on Termination of Pregnancy Act 92 of 1996 may be found to be incompatible with the duty of the state to protect the value of life (and the value of dignity).

In Stewart v Botha 2008 (6) SA 310 (SCA) the Supreme Court of Appeal rejected the action for wrongful life (which we discuss in 11.5 below). In this type of action the disabled child (or his or her parents on behalf of the child) claims from the doctor on the grounds that the doctor’s behaviour (usually an omission or failure to act) was the reason that the parents of the child were denied the choice during the period that the mother was pregnant with the child to have the child aborted because of his or her disability. The court argues that in this type of action the courts are expected to weigh life as a disabled child up against no life. Such an action can only succeed if the court finds that it would have been better for the disabled child never to have been born. This finding implies that life as a disabled person is in itself regarded as damage. To choose no life above life as a disabled person violates the sanctity of human life, and therefore the court rejected the action. The court referred to the sanctity of human life and section 11 of the Constitution in the same breath, and it is clear that the court sees a close link between the concept of sanctity of human life and the constitutional right to life. We submit that this decision supports the idea that the state has a duty to honour, protect and promote the value of life.

Can you imagine that a contractual provision between a hospital and a patient in terms of which the hospital attempts to indemnify itself from liability towards the patient for any harm suffered in hospital could have anything to do with the sanctity of human life?
Well, in *Johannesburg Country Club v Stott* 2004 (5) SA 511 (SCA) the defendant alleged that the indemnity clause excludes liability towards the dependant of a person who died as result of the defendant’s negligence. The court did not need to decide on this point, but Harms JA made the following statement *obiter*:

A final consideration is the radical nature of the exclusion of liability for negligently causing the death of another. Clear wording ... is necessary for reaching this result. Whether it can be done effectively may, in the light of the conclusion reached, be left open. It is arguable that to permit such exclusion would be against public policy because it runs counter to the high value the common law and, now, the Constitution place on the sanctity of life. This Court in *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 (SCA) left scope for such a conclusion.

(Indemnity clauses and the *Afrox* case will be discussed in 4.1.2 and 4.1.2.2.)

The right to life may also be relevant in the context of euthanasia. (This interesting subject is discussed later in 6.2.3.) In terms of common law assisted suicide and active euthanasia are considered unlawful. Where an individual patient wants to have an end made to his/her intolerable suffering, it may be necessary to balance the state’s constitutional obligation to protect life with the individual’s right to control over his/her body (s 12(2)) and right to dignity (s 10).

1.4 The right to freedom and security of the person

Section 12 of the Constitution (freedom and security of the person) provides the following in subsection (2):

Everyone has the right to bodily and psychological integrity, which includes the right –

(a) to make decisions concerning reproduction;
(b) to security in and control over their body; and
(c) not to be subjected to medical or scientific experiments without their informed consent.

Recognition of these rights has also been accorded by common law, although the right referred to in paragraph (a) has never before been formulated in such specific terms. South Africa’s permissive abortion legislation, the Choice on Termination of Pregnancy Act 92 of 1996 finds constitutional support in the express recognition of the right to make decisions concerning reproduction.

However, the justification for this provision may entail more than entrenching a right to abortion. One could argue that it could also support a right to sterilisation (see 8.1 below), or a right not to be denied the opportunity, by the state or any other party, to have children. In the right circumstances this right could possibly be a consideration in respect of artificial insemination (see 8.3 below), embryo transfer, *in vitro* fertilisation, and surrogate motherhood (see 8.4 below), as well as chemical castration of sex offenders (see 7.4 below). Even the controversial matter of reproductive cloning could be affected by this provision (see 7.6.4.3). In addition it is an important consideration when it comes to the question whether parents ought to be able to claim from a doctor who was negligent in performing a sterilisation, or who denied parents the opportunity to end a pregnancy by failing to inform the pregnant mother of a serious abnormality in the foetus. Such claims are known as claims for wrongful pregnancy and wrongful birth, and are discussed below in 11.3 and 11.4 respectively.
The right to security in respect of and control over one’s body is closely linked to the doctor’s duty to obtain an informed consent before performing a medical intervention. This was also confirmed in *McDonald v Wroe* [2006] 3 All SA 565 (C) where the court found that the patient in the specific circumstances was not duly informed about the risk of nerve damage involved in a dental procedure. The court added that performing surgery on a patient without her informed consent amounted to violation of her right to bodily integrity as enshrined in section 12(2) of the Constitution. (Informed consent is discussed in detail in 5.3.)

This right undoubtedly arises where there is a medical intervention against a person’s will, such as surgical removal of a bullet. In *Minister of Safety and Security v Xaba* 2004 (1) SACR 149 (D) the court held that a police official is not authorised in terms of the Criminal Procedure Act 51 of 1977 to use violence to effect the surgical removal of a bullet from the leg of a criminal suspect for the purposes of evidence. In the absence of a law of general application authorising the constitutional infringement of the rights in section 12(1)(c) and section 12(2)(b), the requirements of the limitation clause could not be met.

In the United States there have been challenges to compulsory vaccination programmes (*Jacobsen v Massachusetts* 197 US 11 (1905)) and to the fluoridation of water (*Dowell v City of Tulsa* 348 US 912 (1955)) on the basis that such actions constitute unwarranted bodily invasions.

### 1.5 The right to privacy

Section 14 of the Constitution protects the right to privacy in general terms and specifically mentions certain aspects of this right. Privacy is of course also protected by common law, and an example in the context of medical law is the patient’s right to expect the doctor not to make unwarranted disclosures to others regarding the patient’s ailment and the nature of the treatment.

Section 14 of the National Health Act 61 of 2003 also emphasises the patient’s right to privacy and confidentiality. The Act stipulates that all information concerning a user, including information relating to his/her health status, treatment or stay in a health establishment, is confidential. Such information may not be disclosed unless –

- the patient consents in writing to disclosure
- a court order or any law requires that disclosure
- non-disclosure presents a serious threat to public health

A number of cases were brought before our courts where judgments were made regarding aspects of the right to privacy in the context of medical information on which we would like to comment here. Although these cases did not concern liability of healthcare providers or hospitals on the grounds of violation of privacy, they are nonetheless relevant to medical law, as they touch on disclosure of medical information, and emphasise the sensitive and personal nature of such information. (In 10.2.3.1 we return to the subject of violation of privacy, but there we specifically discuss the healthcare provider’s liability on the grounds of violating a patient’s right to privacy.)
Assume that X (we shall rather not disclose his real identity) has a serious and sensitive problem arising from his reckless and disgusting behaviour. His conscience is troubling him. He has a nasty venereal disease which he contracted during his frequent visits to brothels on his business trips, and he is utterly ashamed. X is married, and is very aware that he has behaved in a morally reprehensible manner. X realises that he has to visit a doctor urgently, but keeps on avoiding this.

Put yourself in X’s shoes for one minute. Apart from shame, what would keep you from seeing the doctor?

It is a trite view in medical law that the doctor’s duty to maintain confidentiality contributes to better health care, as patients can feel confident that highly personal information in respect of their illnesses which they share with the doctor will not be divulged. Certain ailments sometimes carry stigma, even though the affected person is in no way morally “responsible” for this illness. Consider mental illness, for example. In **NM v Smith (Freedom of Expression Institute as Amicus Curiae) 2007 (5) SA 250 (CC)** the names and HIV status of the three applicants were published in a biography. The Constitutional Court confirmed that in view of the stigma attached by the community to HIV, and the discrimination and intolerance following the disclosure of a person’s HIV status, people should be protected by law against gratuitous disclosure of such status. MadalaJ said (par [42]):

>The affirmation of secure privacy rights within our Constitution may encourage individuals to seek treatment and divulge information, encouraging disclosure of HIV which has previously been hindered by fear of ostracism and stigmatisation. The need for recognised autonomy and respect for private medical information may also result in the improvement of public health policies on HIV/AIDS.

In **Tshabalala-Msimang v Makhanya [2008] 1 All SA 509 (W)** the provisions of the National Health Act 61 of 2003 and in particular section 17 were applied to protect the patient’s right to privacy in respect of her healthcare records. This was not a case attempting to claim damages with the **actio iniuriarum**. The facts were as follows: the then Minister of Health was admitted to a private hospital for treatment. The respondents (editor, journalist, owner and publisher of the *Sunday Times*) published an article in the newspaper, elaborating on the Minister’s medical treatment in the hospital. Amongst others it was averred that the applicant abused her power while receiving treatment in the hospital, that she overindulged in alcohol, and also transgressed some hospital rules. The Minister and the hospital (applicants) approached the court to *inter alia* order that the Minister’s health records, which were in possession of the respondents, be returned to the applicants. The Minister contended that the respondents contravened section 17 of the National Health Act 61 of 2003. The court considered the provisions of sections 14 to 17 of said Act, and reached the following conclusion:

>It is clear that in terms of the National Health Act the medical records of a person are private and confidential. Generally speaking, where a person acquires knowledge of private facts through a wrongful act of intrusion, any disclosure of such facts by such person or by any person, in principle, constitutes an infringement of the right to privacy.
The court said the following on the reason why medical information should be regarded as confidential:

The reason for treating the information concerning a user, including information relating to his/her health status, treatment or stay in a health establishment as confidential is not difficult to understand. The confidential medical information invariably contains sensitive and personal information about the user. This personal and intimate information concerning the individual’s health, reflects sensitive decisions and the choices that relate to issues pertaining to bodily and psychological integrity as well as personal autonomy. Section 14(1) of the National Health Act imposes a duty of confidence in respect of information that is contained in a user’s health record. This is simply because the information contained in the health records is information that is private.

In considering the question why medical records should be regarded as confidential, Jajbhay J emphasised the autonomy of the patient in respect of disclosing information, and also pointed out that confidentiality is regarded as so important, that the National Health Act makes breaching thereof punishable under certain circumstances:

The unlawful disclosure of the information contained in the health record will cause extreme trauma as well as pain to the user. This information is confidential because it is the user who has control over the information about himself or herself. It is also the user who can decide to keep it confidential from others. In the National Health Act, the Legislature considered the confidentiality of the information important enough to impose certain criminal sanctions in the event of the breach of the confidentiality. In terms of the Constitution, as well as the National Health Act, the private information contained in the health records of a user relating to the health status, treatment or stay in a health establishment of that user is worth protecting as an aspect of human autonomy and dignity. This in turn includes the right to control the dissemination of information relating to one’s private medical health records that will definitely impact on an individual’s private life as well as the right to the esteem and respect of other people.

1.6 The right to health care

Section 27(1)(a) of the Constitution provides as follows:

Everyone has the right to have access to –

(a) health care services, including reproductive health care

Section 27(2) provides that the state must take reasonable legislative and other measures, within its available resources, to achieve progressive realisation of these rights. (We discuss this duty and government’s proposed system of National Health Insurance [NHI] in study unit 2.)

Section 27(3) provides emphatically that no one may be refused emergency medical treatment.

Currie and De Waal The Bill of Rights Handbook 5 ed (2005) 593 contend that section 27(3) may be applied horizontally, so that private hospitals are also legally bound to provide emergency treatment. Note that free emergency medical treatment is not guaranteed. Although no one may be refused emergency medical treatment because of lack of funds at a hospital which is able to provide it, the hospital may, after providing such treatment, attempt to recover payment.
Section 5 of the National Health Act 61 of 2003 imposes a duty similar to that in section 27(3) in respect of doctors, nurses, hospitals, et cetera, stipulating that a health care provider, health care worker or health care institution may not refuse any person emergency medical treatment.

In *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC) the appellant, a 41 year old diabetic suffering from ischemic heart disease, cerebro-vascular disease and irreversible chronic kidney failure applied for dialysis treatment at a state hospital. Regular kidney dialysis could prolong his life. He was not admitted to the kidney dialysis programme, as the hospital did not have sufficient means to provide dialysis to all patients suffering from chronic kidney failure. The policy of the hospital was to admit patients with acute kidney failure who could be cured by dialysis to the programme. Patients with irreversible chronic kidney failure were not automatically admitted to the programme, but in accordance with a set of guidelines. The primary requirement for admittance according to these guidelines was that the patient must be eligible for a kidney transplant. Such patient would then receive dialysis until an organ donor was found and a transplant done. The guidelines made it clear that a patient with significant vascular or heart disease would not be eligible for a transplant. As the appellant suffered from ischemic heart disease and cerebro-vascular disease, he was not eligible for a kidney transplant and was not admitted to the dialysis programme. He brought an urgent application before the High Court for an order that the hospital provide him with ongoing dialysis, and that the respondent not refuse him admittance to the kidney unit of the hospital. The application was dismissed, as was the appeal to the Constitutional Court.

The Constitutional Court found that the duty placed on the state in terms of section 27 depends on the means available for such purposes, and that the corresponding rights are also limited on account of a lack of means.

The court was of the opinion that the normal meaning of the words “emergency medical treatment” did not include ongoing treatment of chronic diseases in order to prolong life. The Constitutional Court considered the meaning of emergency medical treatment. Chaskalson P held that the purpose of the right not to be refused such treatment was that “[a] person who suffers a sudden catastrophe which calls for immediate medical attention ... should not be refused ambulance or other emergency services which are available and should not be turned away from a hospital which
is able to provide the necessary treatment”. What the constitutional provision required was that remedial treatment that was necessary and available, be given immediately in order to avert harm. Madala J was of the opinion that there “is some suddenness and at times even an element of unexpectedness in the concept emergency medical treatment”.

As the appellant suffered from chronic kidney failure that required two or three dialysis treatments a week, it could not be said that his was a case of emergency that necessitated immediate remedial action. It was more an ongoing state of affairs resulting from the deterioration of his kidney function, and it was incurable. The court found section 27(3) not applicable.

The court further found that the appellant’s claim to receive dialysis at a state hospital had to be considered in terms of sections 27(1) and (2), and not in terms of section 27(3). In terms of sections 27(1) and (2) everyone has the right to have access to health services supplied by the state, within its available means. As there were far more patients with chronic kidney failure than dialysis machines to treat these patients, guidelines were set up to help medical personnel make the soul-wrenching decisions on who will receive treatment. Application of these guidelines meant that far more patients benefitted from the programme than would have been the case had the limited number of dialysis machines been used to keep people with chronic kidney failure alive. Application of the guidelines ensures a greater probability of more beneficial treatment, as it is aimed at a cure and not merely at caring for patients in a chronically ill state.

It would place a considerable burden on the health care budget if all patients with kidney failure were to receive dialysis. The provincial administration responsible for health services has to decide on the funding for health care, and which areas should receive priority. A court would not readily interfere with rational decisions taken in good faith by political organs and health care authorities charged with the responsibility for such matters.

In Treatment Action Campaign v The Minister of Health 2002 TPD (unreported) the applicants sought an order against the Minister of Health and the health authorities of all provinces (except those of the Western Cape) to compel them to implement an effective national programme to prevent or reduce mother-to-child transmission of HIV (the AIDS virus), which would include the dispensing of Nevirapine to pregnant women who are HIV positive, and to their babies. Nevirapine is an antiretroviral drug, that is, it may prevent or inhibit the spread of HIV. The applicants described to the court the alarming rate of mother-to-child transmission and the impressive reduction that might be achieved by administration of the drug. It was claimed that a single dose of the drug can reduce this form of transmission by 50%, but this allegation was disputed by the respondents, who maintained that the success rate was probably considerably lower. The respondents further in general contended that immediate implementation of antiretroviral treatment in these cases would be impossible because of insufficient financial resources.

The High Court (per Botha J) came to the conclusion, with special regard to section 27 of the Constitution, that a countrywide prevention programme of this kind “is an ineluctable obligation of the State”. Moreover, “with Nevirapine it is affordable” if the programme is properly planned. What was required in the opinion of the court was “a plan that moves towards comprehensive coverage”. The court accordingly made an order to this effect. It is clear from the judgment that to require immediate implementation would be unreasonable. The respondents were ordered to report back to the court within approximately three months on the status of their planning.

The decision of the Transvaal High Court was essentially confirmed by the Constitutional Court in Minister of Health v Treatment Action Campaign (No 2) 2002 (5) SA 721 (CC). The Constitutional
Court held that the government policy whereby Nevirapine was available only in certain research sites within the public sector was inflexible and unconstitutional.

Hospitals and clinics that had testing and counselling facilities should be able to prescribe Nevirapine where it was medically indicated. The training of counsellors ought to include training for counselling on the use of Nevirapine, which should not be difficult. In addition government would need to take reasonable measures to extend the testing and counselling facilities to hospitals and clinics throughout the public health sector beyond the test sites to facilitate and expedite the use of Nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV. It was essential that there be a concerted national effort to combat the HIV/AIDS pandemic. That did not mean that everyone could immediately claim access to such treatment, although the ideal was to achieve that goal. Every effort, however, had to be made to do so as soon as reasonably possible.

1.7 The rights of children

Section 28(1)(c) of the Constitution (children) provides inter alia that every child has the right to basic healthcare services. Undoubtedly the scope of this right will in due course be defined more closely by the Constitutional Court. It is also important to note the provisions of section 28(1)(b) in terms of which every child has the right to family care or parental care, or to appropriate alternative care when removed from the family environment. In Government of the Republic of South Africa v Grootboom 2001 (1) SA 46 (CC) the court confirmed that paragraphs (b) and (c) should be read concurrently. These two paragraphs ensure that children will be cared for properly by their parents or families, and that they will receive proper alternative care when removed from parental or family care.

In Minister of Health v Treatment Action Campaign (No 2) 2002 (5) SA 721 (CC), which we discussed in 1.6 in the context of the right to healthcare, the Constitutional Court also considered sections 28(1)(b) and (c) (at paragraph 78–79). The applicants and amici curiae based their case on these two paragraphs. The state contended that paragraph (c) places a duty on parents of the new-born and not on the state to provide the child with the required basic healthcare services. The court found that the duty to provide such services rests primarily on the parents. However, that does not mean that the state has no duty towards children who are cared for by parents or their families. In evaluating government policy it should be borne in mind that this case concerns new-born babies, whose lives may be saved by administering Nevirapine at birth to mother and child. Administering Nevirapine is a simple, cheap and potentially life-saving intervention which is achievable within the available government means. In respect of the children, a single dose of Nevirapine given to mother and child in order to protect the child against HIV transmission is essential. The court pointed out that the needs of the children should take precedence, and that the fact that they are not able to obtain the medication, gravely violates their ability to enjoy all the rights to which they are entitled by law.

The court found that the state is obliged to ensure that children enjoy the protection as envisaged in section 28, which protection arises when the right to parental or family care is not realised. Children born in state hospitals or clinics are mainly born from mothers who are indigent and cannot afford private medical treatment. These children are mainly dependent on healthcare services provided by the state.

See also Hay v B 2003 (3) SA 492 (W) which we discuss in 5.4.2.1.
1.8 The right to information

Section 32 of the Constitution (access to information) provides as follows in subsection (1):

Everyone has the right of access to any information held by

- the state
- another person and that is required for the exercise or protection of any rights.

This provision clearly entitles patients to access to medical records pertaining to themselves, whether such records were compiled in state hospitals or clinics, or private healthcare facilities or by medical practitioners in private practice. The Promotion of Access to Information Act 2 of 2000 was enacted to give effect to this right.

The provisions of this Act make it easier for patients to gain access to information in their hospital or medical records, both in the public (s 30) and the private (s 61) sectors. Regulations promulgated in terms of the Act set out the procedure to be followed.

1.9 The right to just administrative action

Section 33 of the Constitution (just administrative action) gives everyone the right to administrative action that is lawful, reasonable and procedurally fair, including the right to be given written reasons for administrative action affecting one’s rights adversely. These provisions would be also applicable to professional bodies such as the Health Professions Council of South Africa (HPCSA) which exercise disciplinary functions. This function of the HPCSA is discussed in 3.8 below.

The Promotion of Administrative Justice Act 3 of 2000 was enacted to give effect to section 33 of the Bill of Rights.

1.10 The rights of prisoners

Section 35 of the Constitution, dealing with the rights of arrested, detained and accused persons, provides *inter alia* that everyone who is detained, including every sentenced prisoner has the right to conditions of detention that are consistent with human dignity, including the provision of adequate medical treatment at state expense. The section also guarantees the right of a detained person to communicate with and be visited by that person’s chosen medical practitioner.

In *Van Biljon v Minister of Correctional Services* 1997 (2) SACR 50 (C) the court had to consider the meaning of “adequate medical treatment” as envisaged in section 35(2)(e). The applicants were prisoners who were diagnosed as HIV positive. They brought an application for an order that they are entitled to have proper antiviral medicine prescribed for and supplied to them at state expense. Antiviral medicine was prescribed to the first and second applicants, but the prison authorities did not supply the medicine.

The respondents based their case on the premise that what constituted “adequate medical treatment” for prisoners had to be determined by, or be of the same standard as, treatment given by provincial hospitals to patients who are not prisoners. Evidence was brought before the court that patients with similar health problems did not receive antiviral medicine in state hospitals mainly on account of budgetary limitations.
The applicants contended that the premise on which the respondents’ case was based was fundamentally flawed, as the state had a higher duty of care in respect of HIV-positive prisoners than in respect of ordinary citizens with the same infection. They furthermore contended that because the right to adequate medical care to prisoners was guaranteed by the Constitution, prison authorities may never aver that they are unable to provide such care due to lack of funds or budgetary limitations.

The court found that the decision whether antiviral treatment should be prescribed for the first time was a medical decision, and that it was not the task of a court to order that a doctor is obliged to prescribe such treatment. However, once it was established that nothing less than a specific form of medical treatment would be adequate, a prisoner had a constitutional right to receive such form of medical treatment, and the prison authorities could not rely on the defence of inadequate funds. The court nonetheless found that financial circumstances and budgetary limitations were not irrelevant. In determining what was “adequate” the budget of the state should also be considered. If the prison authorities could not afford a certain form of treatment, or if providing such medical treatment would place an unwarranted burden on the state, the court could find that the less adequate medical treatment which the state could afford should be accepted as “adequate medical treatment”.

The court found that the state owes a higher degree of care to prisoners. In contrast to people who are not imprisoned, prisoners had no access to other resources enabling them to gain access to medical treatment. HIV-positive prisoners are more exposed to opportunistic viruses than people with HIV who are not imprisoned. The court ordered that even if it were accepted as general rule that prisoners are entitled to no better care than the state provides to patients who are not incarcerated, such rule may not be made applicable to HIV-infected prisoners, as they are detained in circumstances which render them more prone to opportunistic infectious diseases.

The court noted that the Department of Correctional Services failed to prove that they could not afford to provide antiviral treatment, and found that the medical treatment claimed in the circumstances by the applicants as “adequate medical treatment” should be regarded as the treatment to which the applicants were entitled.

Before closing the subject of the rights of prisoners, we should point out that section 37, dealing with the declaration of a state of emergency, guarantees the right of a person detained due to such declaration to be visited at any reasonable time by a medical practitioner of his or her choice (s 37(6)(c)).

**ACTIVITIES**

1. Briefly discuss the different provisions of the Bill of Rights pertaining to medical and health matters.
2. There is authority in our law that a foetus does not have a right to life. Should it therefore be accepted that a court could never find that any provision of the Choice on Termination of Pregnancy Act 92 of 1996 is in conflict with section 11 of the Constitution?
3. Write brief notes on the following constitutional human rights: the right to life; the right to freedom and security of the person; the right to privacy.
4. What is the relationship between sections 28(1)(c) and 28(1)(b) of the Constitution?

5. B is infected with HIV due to unprotected sexual intercourse with an HIV-positive man. May B demand that a state hospital give her antiretroviral treatment?

6. Discuss the constitutional right of prisoners to medical treatment.

7. Discuss the rights of a citizen to information and just administrative action respectively in respect of medical treatment and healthcare.

8. Which one of the following statements DOES NOT FIT? If a hospital unfairly refuses to admit a patient requiring emergency treatment, it may amount to ...
   
   (1) contravention of section 27(3) of the Constitution of 1996.
   (2) an unfair practice in the healthcare sector (the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000).
   (3) contravention of section 5 of the National Health Act 61 of 2003.
   (4) contravention of section 14 of the National Health Act 61 of 2003.

FEEDBACK

1. The activity as formulated requires a brief discussion of the entire contents of this study unit.

2. No. See 1.3 above. Certain authors are of the opinion that establishing the constitutionality of the Act may not be reduced to the question whether a foetus is invested with a right to life. Carefully read Naude’s and Slabbert’s arguments regarding the duty of the state to promote the right to life and protect the sanctity of life.

3. See 1.3, 1.4 and 1.5. Note that only brief notes are required. If you get such a question in the examination, you should only highlight the most important points of the specific right that you have to discuss. Note that the number of marks allotted to each question should indicate the length of your answers.

4. Section 28(1)(b) determines who are responsible for the care of children, and section 28(1)(c) lists certain aspects of children’s rights in respect of care. One of these is basic health care. In *Grootboom* it was decided that paragraphs (b) and (c) should be read concurrently. These paragraphs ensure that children will be properly cared for by their parents or families, and that they will receive alternative care in the absence of parental or family care. In *Treatment Action Campaign* the court pointed out that, although the duty to provide healthcare to children primarily rests on the parents, it does not mean that the state never has a duty towards children who are cared for by their parents or families. The court further said that children of indigent mothers who are born in state hospitals or clinics are mainly dependant on the state for healthcare services. See 1.7.

5. In principle B would be entitled – in any event if she is indigent – to being supplied with antiretroviral treatment. But considering the scope of the HIV/AIDS pandemic in South Africa and the limited resources of the state, some balance must be struck between the entitlement of a patient and the duties of the state. The *Treatment Action Campaign* case, discussed in part 1.6 above must be carefully considered.

6. Everything discussed in 1.10 above should be given here.

7. Reasonableness is a key consideration in this respect. See 1.8 and 1.9.

8. The correct answer is (4), since this is the statement that does not fit. Usually, multiple-choice questions are phrased in such a way that you are required to identify
the correct statement/phrase/word. However, in this instance you were required to identify the statement that does not fit. The “does not fit” is given in bold and in capital letters. It is interesting that all three the other statements are correct. See 1.2 and 1.6. You should always try to integrate your knowledge, in other words, to make connections between different aspects of the work. Different sections of the work should not be studied in isolation.

### GLOSSARY

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>abortion</td>
<td>Separating and expelling, by medical or surgical means, the contents of the uterus of a pregnant woman.</td>
</tr>
<tr>
<td>actio iniuriarum</td>
<td>The delictual action by means of which satisfaction (solatium) is claimed for the wrongful and intentional infringement of a personality interest. (There are certain exceptions to the rule that intention is required – sometimes all that is required is negligence, and sometimes no fault is required.) Pronunciation: “UK-tee-oh in-you-ree-AH-room”.</td>
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<tr>
<td>active euthanasia</td>
<td>The expression “active euthanasia” is used to refer to the situation where someone performs an intentional deed to end the life of another who has an incurable disease, with a view to end that person’s suffering.</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome. A syndrome of the immune system characterised by opportunistic diseases. The HIV which causes AIDS is transferred in bodily fluids (in particular blood and semen) through sexual intercourse, sharing contaminated needles (e.g. for intravenous drug use), accidental pricking by a needle (e.g. when a doctor accidentally pricks him- or herself with a contaminated needle), contact with contaminated blood, or transfusion of contaminated blood or blood products. The HIV may also be transferred from an infected mother to her baby in the uterus, or through contact with her blood during childbirth, or through breast milk. Normal social contact with HIV-positive persons carries no risk of infection. The syndrome leads to depletion of the T4-lymphocytes, causing suppression of the immune responses of the body.</td>
</tr>
<tr>
<td>amici curiae</td>
<td>Literally “friends of the court”. Pronunciation: “AH-me-key KOO-ree-eye”. This is the plural form of the Latin amicus (“friend”) + curiae (the genitive of curia, Latin for “court”). An amicus curiae is someone who is not party to the litigation, but believes that the finding could impact on his or her interests, and advises the court.</td>
</tr>
<tr>
<td>antiretroviral drug</td>
<td>A drug used to stem a retrovirus, mainly HIV.</td>
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<tr>
<td>antiviral medicine/treatment</td>
<td>A drug which destroys a virus or suppresses replication of a virus, inhibiting its ability to multiply.</td>
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<tr>
<td>artificial insemination</td>
<td>A technique whereby sperm-carrying semen from a man is injected into a woman in order to bring about a pregnancy. Sperm from either the woman’s husband or a sperm donor may be used.</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>assisted suicide</td>
<td>When someone commits suicide with another’s help, e.g. a family member, friend or doctor. The final act is committed by the suffering person.</td>
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<tr>
<td>atherosclerosis</td>
<td>Disease of the arteries characterised by the deposition of plaques of fatty material on their inner walls.</td>
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<tr>
<td>cerebro-vascular</td>
<td>Disease of the blood vessels, in particular the arteries supplying the brain with oxygenated blood. Usually caused by atherosclerosis; may lead to a stroke.</td>
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<tr>
<td>disease</td>
<td></td>
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<tr>
<td>chemical castration</td>
<td>Administering a chemical substance which reduces or suppresses both the sexual urge of a male and his ability to perform the sexual act.</td>
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<tr>
<td>dialysis</td>
<td>A process where a machine is used to remove poisonous substances and metabolic waste from the blood. Used in the case of kidney failure to perform the blood purification function of the kidneys. The blood flows through a system of pipes from the body to a dialysis machine or dialysis membrane, which removes the waste products, poisons and extra fluid from the blood. The clean blood flows from there back through a set of pipes into the body. From the Greek: dia (separate) + lysis (loosen).</td>
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<tr>
<td>embryo</td>
<td>The pre-foetal product of conception in the first development phase, from implantation to approximately the end of the eighth week after conception. The embryonic stage ends when blood circulation between the mother and the growing organism has been established.</td>
</tr>
<tr>
<td>embryo transfer</td>
<td>Transferring a fertilised egg (zygote or embryo) from “mother” A to “hostess” B, who then carries the foetus.</td>
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<tr>
<td>euthanasia</td>
<td>Hastening the death of an intolerably suffering person to end the suffering. Also called “mercy killing”.</td>
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<tr>
<td>fluoridation of water</td>
<td>A general custom worldwide to add fluoride to municipal drinking water to ensure that people who drink the water ingest enough fluoride to protect them against tooth decay. However, some people believe that this practice is detrimental to health.</td>
</tr>
<tr>
<td>foetus</td>
<td>After having grown in the uterus for approximately two months, the embryo is called a foetus. At this stage blood circulation between mother and organism and the general anatomy of the growing organism have been established. The foetal stage lasts until birth.</td>
</tr>
<tr>
<td>GG</td>
<td>Abbreviation for Government Gazette, published by the government printer. All acts and regulations are promulgated in the Government Gazette.</td>
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<tr>
<td>Health Professions Council of South Africa</td>
<td>A statutory body governed by the Health Professions Act 56 of 1974. It is the successor of the old South African Medical and Dental Council (SAMDC), colloquially known as the Medical Council</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus; the virus which causes AIDS.</td>
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<td>HPCSA</td>
<td>Health Professions Council of South Africa.</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<td>-------------------------------</td>
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</tr>
<tr>
<td>indemnity clause</td>
<td>A clause in a contract in terms of which the liability of a party to the contract, or the remedies available to the other party, are excluded, limited or amended. The liability may arise from a contract, a delict or any other source. An indemnity clause which violates public interest will be null and void.</td>
</tr>
<tr>
<td>in vitro fertilisation</td>
<td>For the purposes of the regulations governing artificial fertilisation – the process of spontaneous fertilisation of an ovum with a male sperm outside the body in an authorised institution.</td>
</tr>
<tr>
<td>ischemic heart disease</td>
<td>A heart disease caused by an insufficient supply of oxygen-rich blood to the heart. There are various acute or chronic ischemic heart diseases.</td>
</tr>
<tr>
<td>limitation clause</td>
<td>Section 36 of the Constitution, 1996, in terms of which the rights in the Bill of Rights may sometimes be limited, and which sets out the criteria for such limitations.</td>
</tr>
<tr>
<td>mercy killing</td>
<td>See “euthanasia”.</td>
</tr>
<tr>
<td>Nevirapine</td>
<td>An antiretroviral drug.</td>
</tr>
<tr>
<td>reproductive cloning</td>
<td>Cloning – creating an exact copy – of a human being for purposes of procreation.</td>
</tr>
<tr>
<td>sanctity of human life</td>
<td>A concept often encountered in biomedical ethics and medical law. Although it is rooted in Judeo-Christian ethics, it also enjoys great support in secular ethics. It embodies the idea that human life has intrinsic value. A human being should thus be respected merely by virtue of being human.</td>
</tr>
<tr>
<td>stroke</td>
<td>The most common disorder affecting the nervous system, also referred to as a cerebro-vascular accident. Strokes occur when blood circulation to an area of the brain is interrupted. The deprivation of blood supply is called ischemia. Ischemia results in deficient delivery of oxygen and nutrients to the affected cells, causing vital brain tissue to die. The most common cause of strokes is blockage of a cerebral artery by a blood clot. Other causes include progressive narrowing of brain vessels by atherosclerosis.</td>
</tr>
<tr>
<td>surrogate motherhood</td>
<td>Motherhood made possible by contract between a surrogate mother and a commissioning parent in terms of which the surrogate mother will be artificially inseminated for the purpose of delivering a child for the commissioning parent, and where the surrogate mother undertakes to hand over such child at birth or shortly thereafter to the commissioning parent, so that the child legally becomes the child of the commissioning parent.</td>
</tr>
<tr>
<td>wrongful birth</td>
<td>Where parents (or a parent) of a disabled child themselves claim from the party who allegedly is responsible for failing to prevent the child’s birth.</td>
</tr>
<tr>
<td><strong>wrongful life</strong></td>
<td>Where a disabled child or the parents (or parent) of such child institute an action against the party who allegedly is responsible for failing to prevent the birth (life) of such child.</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>wrongful pregnancy</strong></td>
<td>Where the parents (or parent) of a healthy but unwanted child claims from the party who allegedly is responsible for failing to prevent the conception of the child or the mother's pregnancy. Also known as wrongful conception.</td>
</tr>
</tbody>
</table>
STUDY UNIT 2

The South African health care system

Contents

2.1 Introduction
2.2 Regulation of medical, dental, nursing and supplementary health service professions
2.3 Hospital and state medical services
2.4 Public health
2.4.1 The National Health Act 61 of 2003
2.4.2 Other legislation
2.4.3 National Health Insurance (NHI)
Activities
Feedback
Glossary

Learning outcomes

When you have completed this study unit, you should be able to

- discuss the basic juridical nature of the South African health care system
- name the most important acts of Parliament governing health services in South Africa
- discuss the general characteristics of hospital and medical services provided by the state
- name and describe the categories of persons who qualify for free health services at public health care institutions, as well as the type of service each category qualifies for
- discuss the main functions of the National Health Act 61 of 2003
- discuss government policy on a system of National Health Insurance

2.1 Introduction

In essence the South African system of healthcare is a non-socialised system. Although a substantial number of medical doctors and supplementary healthcare professionals and the majority of nurses are employees of the National Department of Health, the provincial administrations and local authorities, most of the medical doctors, dentists and pharmacists are not employed by the state but practise independently for their own account. Private practitioners and private hospitals attend to those who can afford to pay for the services they render, either from their own funds or through the medical scheme that they belong to. Medical schemes provide a form of medical insurance and are governed by Medical Schemes Act 131 of 1998. Because of the relatively high
costs involved, membership of **medical schemes** is to a large extent restricted to the more affluent. In the past number of years membership fees have risen annually at a higher percentage than inflation. Of the 180 **medical schemes** in existence in 2001 a large number had by 2009 gone under, been placed under curatorship or had merged with another scheme, leaving only about 102 still functioning. In many instances membership benefits were cut, so that many members' benefits were exhausted before the end of the year. In 2009 approximately 16,2% of the population had medical cover by a **medical scheme**. Employers (including government) often subsidise employees' **medical scheme** membership fees. In terms of their policy of 2005 the National Department of Health hopes to make membership of **medical schemes** more affordable in order to enable the high percentage of the South African population who are currently excluded to enjoy the advantages of medical-scheme membership. According to the Department of Health roughly between 75 and 80% of the population has limited access to health services (The Charter of the Health Sector of the Republic of South Africa, released by the Minister of Health on 28 Oct 2005, par 2.2.7.)

In comparison to the percentage of the population served by the public health sector and the health burden it has to shoulder, this sector has far fewer resources than the private sector. According to statistics in the policy document of the Department of Health on a **National Health Insurance** system (see 2.4.3) the private sector spends approximately 49% of the total health budget on approximately 16.2% of the population, while the public sector spends the remaining 51% to serve the 83,8% of the population who mainly use this sector.

The patient who consults a doctor enters into a direct relationship with the practitioner and must remunerate him privately for his service. (The patient may, of course, belong to a **medical scheme** which will pay the practitioner on his behalf.) It is therefore a free-enterprise system in the sense that the relationship between the parties depends on the agreement entered into by them; the state is not a party to the relationship, and nor does the state undertake to provide medical services to all.

As mentioned in 1.6 above, the state is legally obliged to make concerted efforts to achieve the progressive realisation of access to healthcare services (including reproductive healthcare services) within the available resources through reasonable legislative and other measures. We are still far removed from the situation where an individual has an absolute right to healthcare in the sense that the state is legally obliged to provide such care free of charge, irrespective of the economic status of the patient needing medical or hospital services. Government regards its planned initiative to introduce a system of **National Health Insurance** as an important step on the way to realise the right to access to health services. However, implementing such a scheme is extremely expensive in view of South Africa’s limited tax base. Even an economic giant such as the USA has until now (2012) not been able to realise such a system.

As far as the terms of the agreement between doctor and patient are concerned, their relationship is not, however, a “free-enterprise” type of relationship in the full sense of the word. The law has placed important limitations on the terms of the contract between doctor and patient. Thus a doctor is not at liberty to charge the patient any fee he wishes or that the patient is willing to pay. The Health Professions Act 56 of 1974 provides for disciplinary control by the **Health Professions Council of South Africa (HPCSA)** to ensure that doctors’ fees are reasonable (s 53; for details see 3.9 and 4.1.3). If an unreasonable fee was charged and a patient applied to the **HPCSA** for determination, the fee will not be recoverable in so far as it is unreasonable.

Another legal limitation on the contents of the contract between doctor and patient is that a doctor may probably not enter into an agreement whereby the patient undertakes to assume the risk for negligent treatment. As yet we have not had a court decision on the legal validity of such an
agreement, but the HPCSA will probably regard such an agreement as unethical. The provisions of the Consumer Protection Act 68 of 2008 also play a role in this regard. (See also a more detailed discussion of this subject in 4.1.2 and in particular 4.1.2.1 and 4.1.2.3.)

2.2 Regulation of medical, dental, nursing and supplementary health service professions

The medical, dental, nursing and supplementary health service professions are not state-controlled, but the law makes provision for registration by professional boards and for the control by these boards of standards of conduct for practitioners. The Health Professions Act 56 of 1974 governs medical and dental practitioners as well as health-service personnel such as psychologists, occupational therapists, chiropodists, physiotherapists, medical technologists, optometrists, orthopaedic orthotists and prosthetists, radiographers, speech therapists, dieticians and food inspectors.

The nursing profession is governed by the Nursing Act 33 of 2005, the pharmacy profession by the Pharmacy Act 53 of 1974, dental technicians by the Dental Technicians Act 19 of 1979, and practitioners such as chiropractors, homeopaths, naturopaths, osteopaths, herbalists and certain other categories of health practitioners by the Allied Health Professions Act 63 of 1982. The Traditional Health Practitioners Act 22 of 2007 regulates traditional healers, but only a few of the sections of this Act have come into operation at the time of writing of this study guide.

All these acts make registration or enrolment on a professional register or list a prerequisite for the practice of the branch of medicine or technology involved, and penalise practise by an unregistered person. (Note that in terms of the Health Professions Act 56 of 1974 it is a criminal offence for an unregistered person to perform an act deemed to pertain to a health profession as prescribed in the Act. See 3.7.2 below.)

The scope of activities that may be undertaken by members of a particular profession is subject to limitations, except in the case of medical practitioners and dentists.

As far as medical practitioners are concerned the only statutory limitation imposed on their practice is that a doctor who is not registered as a dentist may not perform acts pertaining to dentistry except in cases of emergency or where no dentist is readily available (see 3.7.4 below). Furthermore there is the rule of professional ethics whereby it is improper conduct for a doctor or dentist to perform professional acts for which he is inadequately trained and/or insufficiently experienced (except in an emergency). Under common law a practitioner who performs such acts may be held liable for the damage or injury suffered by the patient as a consequence of these acts, on the basis of negligence. The South African Medical and Dental Council (SAMDC) – the predecessor of the HPCSA – made a rule whereby registered specialists may not perform acts which do not belong to their speciality.

2.3 Hospital and state medical services

Although there is no national health service in South Africa run by the state as is the case in England, provision has been made for state and provincial hospitals and clinics to offer medical and hospital services for the lower-income groups and indigent persons either free or at a reduced rate. Government is also in the process of introducing a system of National Health Insurance which will
ensure universal access to health services to all citizens and permanent residents of South Africa (see 2.4.3).

The National Health Act 61 of 2003 (s 4(1)) empowers the Minister of Health to prescribe conditions subject to which categories of persons are eligible for such free health services at public health establishments as may be prescribed. Section 4(3) of the Act provides that, subject to any condition prescribed by the Minister, the state and clinics and community health centres funded by the state must provide –

(a) pregnant and lactating women and children below the age of six years, who are not members or beneficiaries of medical aid schemes, with free health services
(b) all persons, except members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases, with free primary healthcare services
(c) women, subject to the Choice on Termination of Pregnancy Act 92 of 1996, with free termination of pregnancy services.

Despite substantial growth in the number of private hospitals and clinics over the past few decades, state, provincial and municipal hospitals and clinics still exceed the private institutions both in number, and in general, also in size.

A substantial number of medical doctors and supplementary health-service professionals and the majority of nurses in the Republic are employed by the Department of Health of the central government and by the provincial administrations. Doctors and nurses are also employed by municipalities and other local authorities.

State and provincial hospitals also admit private patients, in other words, paying patients who are treated by private practitioners. These hospitals offer special facilities which are not necessarily provided by all private institutions, for example casualty departments and intensive-care units.

It is to be noted that no-one has an absolute right to be admitted to a hospital, whether private or public. Admission to a state hospital is a matter which in terms of provincial laws is ordinarily within the discretion of the superintendent of the hospital. Provided that the superintendent has exercised his discretion in a reasonable manner and with due regard to the urgency of each case, his decision cannot be challenged.

Private hospitals in principle have an absolute discretion concerning whom they will admit as patients. It is submitted, however, that in a case of a life-or-death emergency, where there is no state hospital within easy reach, a private hospital which is equipped with a casualty section may by common law be obliged to admit the patient involved. This view is supported by section 27 of the Constitution which provides *inter alia* that no-one may be refused emergency medical treatment. See also *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC) discussed above in 1.6. Section 5 of the National Health Act 61 of 2003 makes it clear that a “health establishment” may not refuse a person emergency medical treatment. “Health establishment” is defined so as to include both public and private establishments.

“Health establishment” includes the whole or part of a private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services.
2.4 Public health

2.4.1 and 2.4.2 need NOT be studied for examination purposes, but must be read for assignment purposes.

As opposed to the rendering of professional medical services, which is essentially a matter for private individuals, the protection and promotion of public health is a matter which falls entirely within the functions of the state, including the provincial administrations, municipalities and district health councils. The Department of Health of the central government plays a leading role in this respect. The main functions of this department and those of the provincial administration and local authorities are described below.

The most important legislation pertaining to national health is the National Health Act 61 of 2003.

2.4.1 The National Health Act 61 of 2003

The objects of the National Health Act are essentially (see s 2) to regulate national health and to provide uniformity in respect of health services in South Africa by –

(a) establishing a national health system which encompasses public and private healthcare providers, and provides the population of the Republic in an equitable manner with the best possible health services that available resources can afford

(b) setting out the rights and duties of health-care providers (doctors and other registered healthcare professionals, nurses, pharmacists, dental technicians, etc), health workers, health establishments (hospitals, clinics, nursing homes, diagnostic centres, etc) and users (ie patients and clients)

(c) protecting and promoting the rights of people to realise the constitutional right of access to healthcare, to a safe environment, the rights of children to basic nutrition and healthcare services, and the rights of vulnerable groups such as women, children, the elderly and disabled persons.

It is clear from section 2 that the Act as such was not intended to set out in full the rights and duties of healthcare providers and patients. First, the common law has over centuries mapped out many of these rights and duties, and, secondly, there are a number of other acts setting out many of these rights and duties.

Section 3 of the Act imposes on the Minister a number of important duties, such as promoting public health, determining policies in this regard, and ensuring the provision of essential health services, all within the limits of available resources. A similar duty is imposed on the National Department of Health, provincial departments and municipalities.

The important duty is further imposed on the Minister to determine eligibility for free health services in public health establishments (see 2.3 above).

2.4.1.1 The National Department of Health

The general functions of the National Department of Health are set out in section 21 of the Act. First and foremost, provision is made for the implementation of the national health policy. Provision is also made inter alia for international liaison, promotion of health norms and standards, training of
human resources, health services in national disasters, anti-pollution measures and integration of health plans of the national department and provincial departments.

### 2.4.1.2 National Health Council

In section 22 the Act makes provision for the establishment of a National Health Council on which persons from various sectors will serve. The Council will have wide-ranging advisory powers.

### 2.4.1.3 National Consultative Health Forum

This body must be established by the Minister of Health (s 24). Its functions are to promote and facilitate interaction, communication and the sharing of information on national health issues between the National Department of Health and certain other bodies.

### 2.4.1.4 Provincial health departments

Chapter 4 of the Act regulates the general functions of provincial departments of health (s 25). A provincial health council must be established for each province (s 26) to perform a wide range of functions (s 27). Provision is further made for provincial consultative bodies (s 28).

### 2.4.1.5 District health system

Provision is made in chapter 5 of the Act for the organisation of health services on municipal level in metropolitan areas and districts.

### 2.4.1.6 National health research and information

Chapter 9 of the Act deals in detail with health research policies and research on or experimentation with human subjects. It is not proposed to go into the detail of the chapter here; reference will again be made to it below when we deal with human experimentation in 6.2.1 and 7.7.

### 2.4.1.7 Health officers and compliance procedure

Chapter 10 of the Act deals in detail with these matters, but a knowledge of the statutory provisions contained in this chapter is not required for the purposes of this module.

### 2.4.2 Other legislation

There are a number of other acts of parliament dealing with public health in the broader sense of the word or aspects thereof, namely the Mental Health Care Act 17 of 2002, the Foodstuffs, Cosmetics and Disinfectants Act 54 of 1972, the Hazardous Substances Act 15 of 1973, the Medical Schemes Act 131 of 1998, the Housing Act 107 of 1997, the National Environmental Management: Air Quality Act 39 of 2004, the Dumping at Sea Control Act 73 of 1980, the International Health Regulations Act 28 of 1974, the Prevention and Treatment of Drug Dependency Act 20 of 1992, the Tobacco Products Control Act 83 of 1993, the National Health Laboratory Service Act 37 of 2000 and the Council for Medical Schemes Levies Act 58 of 2000. In addition to these there are laws of the various provinces and by-laws of municipal councils dealing with hospitals, local health affairs and incidental matters.
2.4.3 National Health Insurance (NHI)

This part must be studied for examination purposes.

As we have seen in 2.4.1.1 the Minister of Health has to promote public health and implement the policy governing public health. On 12 August 2011 the Minister published a document setting out government policy on a system of National Health Insurance (NHI) in GN 657, GG 34523 for public comment and suggestions. The Minister pointed out that hospitals have to improve drastically, infrastructure has to be developed, and human resource systems and an information technology system be put into place in order to be able to implement an NHI. According to the policy document successful implementation of an NHI requires total transformation of healthcare provision, total overhaul of the entire healthcare system, radical changes in administration and management of healthcare, and provision of a comprehensive care package supported by a redesigned primary healthcare system.

The proposed NHI is aimed at ensuring access to healthcare to all citizens and permanent residents of South Africa, irrespective of their socio-economic status. Government plans to introduce the system over a period of 14 years, with pilot projects being launched in 10 districts in 2012.

The document mentions that introduction of an NHI system has to take into account the burden of disease crippling South Africa. Four health problems are highlighted: HIV/AIDS and tuberculosis; mother, infant and child death; non-communicable diseases such as high blood pressure, diabetes, chronic heart and lung diseases, cancer and mental illnesses; injury (in particular due to motor vehicle accidents) and violence (in particular interpersonal violence).

The NHI will be funded from taxes paid by people from higher-income groups and employers. The income base will be kept as wide as possible in order to keep individual contributions as low as possible. SARS will be responsible for collecting the funds. Particulars regarding funding still have to be worked out. A cautious estimate of costs is R125 billion for 2012, R214 billion for 2020 and R255 billion for 2022.

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Too many faults with NHI proposal, says DA

ANDISWE MAKINANA CAPE TOWN, SOUTH AFRICA – Dec 05 2011

The Democratic Alliance has criticised the proposed National Health Insurance (NHI) scheme, saying the government has misdiagnosed the healthcare system’s ailments and its proposed prescription will fail to address the problems.

In August, Health Minister Aaron Motsoaledi published the green paper on the NHI, which seeks to improve access to quality health services for both the rich and poor and to strengthen the under-resourced public health sector.

While funding for the proposed system is yet to be clarified, the state estimates that the NHI, which it seeks to rollout over a 12-year period, would cost R225-billion by 2025.

But the DA argues that its own research shows serious doubts around the feasibility of the NHI and that it could actually work against its objective of providing quality health services.

The party said the government was simply throwing money at a problem, while the same funds could better be used somewhere else.

“The NHI, as presented by the national government in its green paper, is not a cure-all for our public health system. On the contrary, it promises to make our healthcare problems even worse by centralising and over-bureaucratising public health,” said the DA.

DA parliamentary leader Lindiwe Mazibuko said they believe that the poor would suffer more under the NHI because it would divert billions of rands from other development challenges such as provision of basic services, education and housing.

DA’s spokesperson on health, Mike Waters, told journalists in Parliament that the proposed system does not fix the problem of low-quality healthcare provision in the public sector. Instead, the green paper focuses on accessibility and finance, “when we already have universal accessibility” and enough funding to run a quality public health system.

“What it lacks is quality, which should be the government’s main priority,” Waters said.

Waters said the NHI green paper also failed to adequately attend to accountability and management structures.

While the green paper called for an office of standards compliance, its members would be appointed by, and would answer to, the health minister.

“It will not be truly independent, making it vulnerable to political influence,” Waters said.

Human resources were lacking to introduce NHI, which demanded that the current 27 000 doctors be tripled.

South Africa spent R2 766 on public healthcare per person each year – far more than other developing countries. Malaysia, for instance, spent only R2 180 per capita, Thailand R1 700 per capita, Namibia R1 594 per capita, and China a mere R846 per capita.

“Those countries enjoy higher levels of life expectancy than South Africa, which suggests that money is not the primary problem with our public healthcare system,” Waters said.

Alternatively, the party proposed a system which centres on infusing accountability, affordability and efficiency into every level of healthcare. – Additional reporting by Sapa

Mail & Guardian
billion for 2025. The state will own the NHI fund, it will be administered by the public sector, and managed by a chief executive officer assisted by a management team and selected technical committees. It will be accountable to the Department of Health and Parliament. The policy document envisages that the increased expenditure on health will be balanced by decreased expenditure on medical schemes.

The document acknowledges the under-performance of the public health sector, and blames it on mismanagement, lack of funds and declining infrastructure. A drastic overhaul is needed to ensure success. The document is not flattering about the high cost of private healthcare, and stricter price control on healthcare is suggested. The fact that there are fewer doctors in the public health sector than in the private sector is acknowledged. Government faces an enormous challenge to ensure that this disparity is eradicated.

Medical schemes will live on, and members of such schemes will nonetheless have to contribute to the NHI.

The NHI will not pay for cosmetic plastic surgery, cosmetic dental surgery, Botox-treatment or expensive spectacle frames. An Office for Health Standards Compliance will be established by law to set health standards and inspect hospitals. This body will consist of a standards unit, an inspection unit, and an ombudsman.

An attempt will be made to provide more specialists on local health care level, that is, in clinics and smaller hospitals. At present there is shortage of specialists in district hospitals. An integrated team of specialists consisting of a gynaecologist-and-obstetrician, paediatrician, general practitioner, anaesthesiologist, midwife and primary health care nurse should be based at district hospitals so that patients may be seen by specialists as early as possible, before advanced technology and treatment on a higher level is needed. Health care services will also be provided at schools.

**Activities**

1. Discuss the basic juristic nature of the South African health care system.
2. Discuss the general features of hospital and medical services offered by the state.
3. Section 4(3) of the National Health Act 61 of 2003 provides that, subject to any condition prescribed by the Minister, the state and clinics and community health centres funded by the state must provide certain categories of persons with certain health services free of charge. Which of the following statements is correct?
   
   (1) The state must provide all persons, except members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases, with all health care services free of charge.
   
   (2) The duty of the state to provide free medical services to children younger than six years extends only to provision of primary health care.
   
   (3) The state is obliged to provide free abortion services to all pregnant women, also those who are members of a medical scheme.
   
   (4) The state must provide all children below the age of six with free health services.

4. Discuss the main functions of the National Health Act 61 of 2003.
5. Critically discuss government policy in respect of a system of National Health Insurance.
1. At present the South African health care system is non-socialised, which means that it is largely private-sector oriented. The citizen has no absolute right to healthcare. However, government policy now is to introduce a system of National Health Insurance which will ensure access to health care for all citizens and legal permanent residents of South Africa.

2. South Africa does not have a state-run national health service, but provision has been made for medical and health services to be provided free of charge or at a reduced cost to indigent persons.

3. The correct answer is (3). Please carefully note the different categories of persons, criteria for exclusion of certain persons, and the type of service to which each category is entitled.

4. The National Health Act sets out the broad framework within which the Department of Health and other official bodies must or may act to promote the health of the general public.

5. Introduction of a health care financing mechanism (the NHI) over a period of 14 years commencing in 2012 is envisaged. Particulars are found in 2.4.3 above. You must know these, as well as criticism in the media (as in the news report included), and integrate this with your own view. Keep an eye on the press for information about this very important subject.

GLOSSARY

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>health establishment</td>
<td>For the purposes of the National Health Act 61 of 2003 the whole or part of a private or public establishment, facility, building or place, profit-seeking or non-profit-seeking, which is run or designed to provide in-patient or out-patient treatment, diagnostic or therapeutic intervention, nursing, rehabilitation, palliative, convalescent, preventative or other health care services.</td>
</tr>
<tr>
<td>Health Professions Council of South Africa</td>
<td>A statutory body governed by the Health Professions Act 56 of 1974. It is the successor of the old South African Medical and Dental Council (SAMDC), colloquially known as the Medical Council.</td>
</tr>
<tr>
<td>HPCSA</td>
<td>Health Professions Council of South Africa</td>
</tr>
<tr>
<td>hospice</td>
<td>A facility specialising in care of dying patients. Narcotics (medicine that induces numbness and stupor, and relieves pain) such as morphine, are usually administered in controlled dosages.</td>
</tr>
<tr>
<td>medical scheme</td>
<td>A scheme controlled by the Medical Schemes Act 131 of 1998 which provides some type of medical insurance to members. Members may usually choose between several benefit options linked to different fee structures, depending on how comprehensive such benefits are.</td>
</tr>
<tr>
<td>National Health Insurance</td>
<td>A health care financing mechanism proposed in 2009 by the Minister of Health with the aim to provide universal access to health care to all citizens and legal permanent residents of South Africa.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>NHI</td>
<td>National Health Insurance</td>
</tr>
<tr>
<td>palliative</td>
<td>Relieving agonising or intense symptoms. Indicates relief of symptoms without curing of the underlying disease. Hospice care is a good example of palliative treatment. Palliative medicines are often used in treatment of diseases such as cancer, especially in the terminal phase.</td>
</tr>
<tr>
<td>professional boards</td>
<td>Bodies established by the Minister on recommendation of the Health Professions Council of South Africa with reference to those professions for which a register is kept in terms of the Health Professions Act 56 of 1974.</td>
</tr>
<tr>
<td>SAMDC</td>
<td>South African Medical and Dental Council, predecessor of the HPCSA.</td>
</tr>
<tr>
<td>South African Medical and Dental Council</td>
<td>Predecessor of the HPCSA.</td>
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Regulation of the medical profession by the law

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3.16 Rights of doctors and other health care personnel

3.1 Introduction

The Health Professions Act 56 of 1974 is the “charter” of the medical practitioner in South Africa. However, it goes beyond the medical doctor in that it also governs the practice of dentistry and psychology, and supplementary health services (apart from nursing, midwifery, pharmacy, homeopathy and chiropractice).

Examples of persons supplying supplementary health services are occupational therapists, physiotherapists, medical technologists, optometrists, radiographers speech therapists and audiologists, chemical-pathology technologists, dieticians, dental hygienists, anaesthesia assistants, food inspectors, biomedical engineers, radiotherapy technologists, medical scientists and clinical biochemists.

3.2 The Health Professions Council of South Africa (HPCSA)

The Health Professions Council of South Africa (HPCSA) is governed by the Health Professions Act 56 of 1974. It came into existence by virtue of Act 89 of 1997, and it is the successor of the old South African Medical and Dental Council (SAMDC), colloquially known as the Medical Council.

The objects of the HPCSA include the following (s 3):

(1) to co-ordinate the activities of the professional boards established in terms of the Act
(2) to promote and to regulate interprofessional liaison between registered professions in the interest of the public

(3) to determine strategic policy with regard to the professional boards and the registered professions for matters such as finance, education, training, registration, ethics and professional conduct, disciplinary procedure, scope of the professions, interprofessional matters and maintenance of professional competence

(4) to consult and liaise with relevant authorities on matters affecting the professional boards in general

(5) to assist in the promotion of the health of the population of the Republic

(6) to control and to exercise authority in respect of all matters affecting the training of persons in, and the manner of the exercise of the practices pursued in connection with, the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in humankind

(7) to promote liaison in the field of training referred to in (6) above, both in the Republic and elsewhere, and to promote the standards of such training in the Republic

(8) to advise the Minister on any matter falling within the scope of this Act in order to support the universal norms and values of health professions, with greater emphasis on professional practice, democracy, transparency, equity, accessibility and community involvement

(9) to communicate to the Minister information of public importance acquired by the HPCSA in the course of the performance of its functions under this Act

(10) to serve and protect the public in matters involving the rendering of health services by persons practising a health profession

(11) to exercise its powers and discharge its responsibilities in the best interest of the public and in accordance with national health policy determined by the Minister

(12) to be transparent and accountable to the public in achieving its objectives and when performing its functions and exercising its powers

(13) to uphold and maintain professional and ethical standards within the health professions

(14) to ensure the investigation of complaints concerning persons registered in terms of this Act and to ensure that appropriate disciplinary action is taken against such persons in accordance with this Act in order to protect the interest of the public

(15) to ensure that persons registered in terms of this Act behave towards users of health services in a manner that respects their constitutional rights to human dignity, bodily and psychological integrity and equality, and that disciplinary action is taken against persons who fail to act accordingly

(16) to submit to the Minister –

(i) a five-year strategic plan within six months of the council coming into office which includes details as to how the council plans to fulfil its objectives under this Act

(ii) every six months a report on the status of health professions and on matters of public importance that have come to the attention of the council in the course of the performance of its functions under this Act

(iii) an annual report within six months of the end of the financial year

(17) to ensure that an annual budget for the council and the professional boards is drawn up and that the council and the professional boards operate within the parameters of such budget.

The HPCSA may establish such committees as it may deem necessary, including disciplinary committees (also known as “professional conduct committees”). The HPCSA may delegate to a committee or a person any or some of its powers, but is not divested of a power thus delegated
The committees may have as many members as determined by the HPCSA. However, at least one of the members must be a member of the HPCSA and act as chairperson (s 10(1)(a)).

The HPCSA shall establish ad hoc appeal committees, each consisting of:

- as chairperson, a person with knowledge of the law with at least 10 years’ relevant experience
- not more than two registered persons drawn from the profession of the registered person in respect of whose conduct a professional conduct committee of a professional board had held an inquiry
- and a member of the HPCSA appointed to represent the community

(The functions of disciplinary committees and disciplinary appeal committees will be discussed below in 3.4, 3.8 and 3.9.)

The HPCSA has general powers to enable it to perform its statutory functions (s 4).

The Minister of Health may, in consultation with the HPCSA, make a range of regulations affecting the education of students and registered persons (s 61). Special mention should be made of the conditions under which registered persons may practise (s 61(c)), and of the registration of specialities (s 61(f)). A regulation may prohibit the use of certain names by unregistered persons (s 61(d)).

### 3.3 Professional boards

The Minister must, on the recommendation of the HPCSA, establish a professional board with regard to any profession in respect of which a register is kept in terms of the Act, or with regard to two or more such professions (s 15).

So far 12 such professional boards have been established. For the purposes of this module the most important of these boards is the Medical and Dental Council. Some of the others are those for Speech, Language and Hearing Professions, Dental Therapy and Oral Hygiene, Psychology, Occupational Therapy and Medical Orthotics, Radiography and Clinical Technology, Medical Technology, Emergency Care Personnel, Optometry and Dispensing Opticians, and Dietetics.

### 3.4 Registration of practitioners

No person may practise any registerable health profession unless he or she is registered in terms of the Health Professions Act 56 of 1974 (s 17(1)(a)).

The Act further prohibits the practising of any profession the practise of which consists mainly of the following (s 17(1)(b)):

1. the physical or mental examination of persons
2. the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in man
3. the giving of advice in regard to such defects, illnesses or deficiencies
4. the prescribing or providing of medicine in connection with such defects, illnesses or deficiencies
unless the person concerned is registered in terms of the Act. This prohibition does not apply to other professions authorised by legislation regulating health care providers (s 17(1)(b)). It is not immediately clear how any person can be registered for a profession that cannot be registered in terms of this Act. This provision could imply that a person who wants to follow a profession that may not be registered in terms of the Act but entails any of the actions mentioned above, must be registered within one of the categories that may be registered. However, the provisions of section 17(1)(b) must not be construed as permitting the performance by a person registered under any of the laws contemplated in that subsection of any act which is not performed in the ordinary course of the practising of his or her profession(s 17(1A).

The Act further contains detailed provisions in respect of applications for registration (s 17). In terms of section (18)(1) the registrar shall keep registers in respect of persons registered in terms of this Act. Certain information must be contained therein, such as the registered persons’ personal particulars and qualifications and the registration category in which they hold registration and the name of their speciality, if any.

The Minister may, on the recommendation of the council, prescribe the South African qualifications which will entitle the holder thereof to registration in any of the registration categories (s 24).

The Act also regulates registration of persons who hold qualifications not prescribed for registration (eg qualifications from foreign countries). A professional board may require that a person who holds such qualification has to pass an evaluation to the satisfaction of persons appointed by such council (s 25(2)). The evaluation could have the purpose of determining whether such person possesses adequate professional knowledge, skill and competence, and whether he or she is proficient in any of the official languages of South Africa. A person with a foreign qualification may only be registered in the category “independent practice” if he or she is a South African citizen or has attained permanent residence status (s 25 (3A)(a)).

For the purpose of promoting education or training for the practising of a health profession, the relevant professional board may register any person not permanently resident within South Africa to practise such profession for such period as the professional board may determine (s 29(1)).

The Act makes provision for removal from the register the name of a practitioner who was found guilty of unprofessional conduct and on whom the penalty of removal had been imposed (s 19(1)(g)). Furthermore the Act makes provision for administrative removal of the name of a practitioner from the register on other grounds, for example:

- failure to pay to the professional board, within three months as from the date on which it became due for payment, any annual fee prescribed by the professional board (s 19(1)(d))
- initial registration in error or through fraud (s 19(1)(f))
- the request by the practitioner to have his or her name removed from the register(s 19(1)(c))

Provision is also made for suspension of registration of health professionals (s 19A(1)) as well as revocation of such suspension (s 19A(4)). For example, the registrar may suspend a person’s registration if he or she

- failed to comply with the requirements in respect of continuing professional development (s 19A(1)(d) – see 3.6 below)
- on the basis of a complaint lodged with the council or information available at the disposal of council is posing an imminent threat or danger to the public in terms of his or her professional practice (s 19A(1)(e))
Any person who is aggrieved by any decision of the HPCSA, a professional board or a disciplinary committee, may appeal to the High Court against such decision. Notice of appeal must be given within one month from the date of the decision (s 20).

3.5 Compulsory community service

Any person registering for the first time for a profession listed in statutory regulations will be required to perform remunerated medical community service for a period of one year before being entitled to practise the profession in question.

The Minister may, after consultation with the HPCSA, make regulations governing community service. The regulations may cover inter alia the place or places at which the service is to be performed, and the conditions of employment (s 24A of the Health Professions Act 56 of 1974).

3.6 Continuing professional education may be required

The HPCSA in consultation with a professional board may make rules which prescribe the following (s 26 of the Health Professions Act 56 of 1974):

- conditions relating to continuing education and training to be undergone by practitioners registered in terms of the Act in order to retain registration
- the nature and extent of such education and training to be undertaken by persons registered in terms of this Act
- the criteria for recognition by the professional board of continuing education and training activities and providers offering such activities
- crimes connected with, and punishments for non-compliance with this section

In 1999 continuing professional education became compulsory for medical practitioners. The HPCSA introduced a programme of Continuing Professional Development. Health practitioners have to accumulate 30 “Continuing Education Units” per 12 month period, and five of these units have to cover ethics, human rights and medical law. Each unit is valid for 24 months from the date on which the activity took place (or ended, in the case of postgraduate study), after which it expires. This means that practitioners have to attempt to accumulate 60 units by the end of their second year of practise, and thereafter to top up the balance with additional units before or at the time of expiry of every 24 month period following thereon.

In terms of section 22 registration certificates remain valid for one year only; thereafter “annual practising certificates” will be issued on payment of the required annual fee and submission of certain information with a statistical value, required by the HPCSA.

Remember that the Act makes provision for suspension of registration if a practitioner fails to comply with the requirements in respect of continued professional education (see 3.4).
3.7 Practise by or performing of specific acts by unregistered persons prohibited

3.7.1 Practise by unregistered persons, and pretending to be registered prohibited

We have seen in 3.4 above that registration in terms of the Health Professions Act 56 of 1974 is a prerequisite for practising a health profession (s 17). Any person who is not registered in terms of this Act and practises a health profession in contravention of section 17 or who pretends to hold such registration is guilty of an offence and on conviction is liable to a fine or to imprisonment for a period not exceeding 12 months or to both a fine and such imprisonment (s 17(5)).

3.7.2 Performing acts which pertain to a health profession by unregistered persons prohibited

The Health Professions Act 56 of 1974 provides in section 33(1) that the Minister of Health, on the recommendation of the HPCSA and the relevant professional board, by regulation may define the scope of any health profession that can be registered in terms of this Act by specifying the acts which shall for the purposes of the application of this Act be deemed to be acts pertaining to that profession.

In terms of this Act it is prohibited for anyone to practise any health profession of which the scope has been defined by the Minister in terms of section 33(1), unless he or she is registered in terms of the Act in respect of such profession (s 34(1)). Any person who contravenes this prohibition is guilty of an offence and on conviction liable to a fine or imprisonment for a period not exceeding 12 months, or a fine as well as such imprisonment (s 34(2)). It would seem that the provisions of section 34 and 17 largely overlap. The provisions of section 34 are more specific in regard to the specific professional category. The provisions of section 34 (unlike those of s 17) cover the case where a person who is indeed registered in terms of the Act, but not in respect of the profession he or she in fact practices – such as where a registered educational psychologist practises as guidance counsellor.

May Janus, who is registered for one profession, circumvent the provision as set out above by mainly practising that profession, but besides that also perform certain actions belonging to another professional category?

Apparently he may do so, and therefore it is not only prohibited for an unregistered person to practise as such, but also to perform an action belonging to a health profession. In terms of section 39(1) of the Health Professions Act 56 van 1974 no person shall perform any act deemed to be an act pertaining to any health profession as may be prescribed under this Act unless he or she

- is registered in terms of this Act in respect of such profession (par (a))
- is registered in terms of this Act in respect of any other profession referred to in section 33 to which such act is also deemed to pertain (par (b)(i))
- practises a health profession in respect of which the registrar in terms of this Act keeps a register and such act is deemed to be an act which also pertains to such profession (b)(ii))
• is registered or enrolled as a nurse under the Nursing Act 50 of 1978, and such act is an act which also pertains to the profession of a nurse (par (e))

A person who contravenes section 39(1) shall be guilty of an offence and on conviction liable to a fine or to imprisonment for a period not exceeding 12 months, or to both a fine and such imprisonment. (It is of course also possible that a person who is not registered in any category in terms of the Act, may be found guilty of the offence described in s 39(2).)

3.7.3 Acts pertaining to the medical profession

The insert above is a copy of and advert for certain services. The person implies that he is able to perform many different wonderful things, such as curing HIV/AIDS, insanity, stress, addiction and chronic illnesses. Is he contravening any of the provisions of the Health Professions Act 56 of 1974?

The regulation defining the scope of the medical profession was promulgated in GNR 237 of 6 March 2009 (GG 31958).
The following acts are hereby specified by the professional board under Regulation 2 as acts which shall, for the purposes of the Act, be deemed to be acts pertaining to the medical profession:

(a) the physical medical and/or clinical examination of any person
(b) performing medical and/or clinical procedures and/or prescribing medicines and managing the health of a patient (prevention, treatment and rehabilitation)
(c) advising any person on his or her physical health status
(d) on the basis of information provided by any person or obtained from him or her in any manner whatsoever –
   (i) diagnosing such person’s physical health status
   (ii) advising such person on his or her physical health status
   (iii) administering or selling to or prescribing for such person any medicine or medical treatment
(e) prescribing, administering or providing any medicine, substance or medical device as defined in the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965)
(f) any other act specifically pertaining to the medical profession based on the education and training of medical practitioners as approved by the professional board from time to time

Regulation 3 provides that the provisions of Regulation 2 shall not be construed as prohibiting –

(a) any person registered under any legislation regulating healthcare providers from performing any act specified in that regulation in accordance with the provisions of such legislation
(b) an intern working at an institution recognised by the HPCSA from performing any function or issuing any certificate or other document which in terms of any law, other than this Act, may be or is required to be performed or issued by a medical practitioner, whether described in such law as a medical practitioner or by any other name or designation, or describing himself or herself as a medical practitioner in connection with the performance of any such function or the issuing of any such certificate or document
(c) a student intern from performing any act specified in that regulation under the supervision of a medical practitioner in the course of his or her training
(d) a dentist from performing any act specified in that regulation in the course of performing any act falling within the scope of dentistry or from using any name, title, description or symbol normally associated with his or her profession
(e) any person from performing any act specified in that regulation in the course of bona fide research at any institution approved for that purpose by the Minister

Regulation 4 confirms that any person who wishes to perform any of the acts prescribed in Regulation 2 shall apply in the prescribed manner to the professional board for registration as a medical practitioner and submit proof of having complied with the prescribed requirements for such registration.

3.7.4 Acts pertaining to the dental profession

Mr Saaed Caries and his young bride, Bisma, are aboard the Scherzo, a large luxury liner registered in South Africa. The voyage is from Port Elizabeth to Mauritius, and is an idyllic experience until Bisma suddenly becomes green in the face with seasickness, and Mr Caries develops a terrible toothache. There is no dentist on
The following acts are hereby specified by the professional board under section 33 as acts which shall, for the purposes of the Health Professions Act 56 of 1974, be deemed to be acts pertaining to the profession of dentistry:

(a) the physical clinical examination of the oral, maxillofacial and related structures of a person
(b) making a diagnosis of diseases, injuries and conditions of the oral, maxillofacial and related structures, including determining the relevance of systemic conditions, and/or giving advice on such conditions
(c) performing dental procedures and/or prescribing medicines aimed at managing the oral health of a patient, including prevention, treatment and rehabilitation
(d) performing any procedure on a patient aimed at fitting or supplying a dental prosthesis or appliance
(e) performing any aesthetic or cosmetic procedure on a patient pertaining to the oral and peri-oral area

Regulation 3 provides that the provisions of Regulation 2 shall not be construed as prohibiting –

(a) a medical practitioner not registered as a dentist from performing, in the course of his or her practice, acts pertaining to the practise of dentistry in cases of emergency or where no dentist is readily available
(b) the employment by and under the supervision of a dentist of any person registered under the Dental Technicians Act 19 of 1979, for the purpose of making or repairing dentures or other dental appliances
(c) any person from making or repairing artificial dentures or other dental appliances for his or her own profit: Provided that such work is carried out on the instructions and to the order of a dentist and does not include the taking of any impression or bite or any trying or fitting in the mouth
(d) a person registered in terms of the Act in respect of a profession related to the practice of dentistry from performing any act pertaining to the practise of dentistry

Regulation 4 confirms that any person who wishes to perform any of the acts referred to in Regulation 2 shall apply in the prescribed manner to the professional board for registration as a dentist and submit proof of having complied with the prescribed requirements for such registration.

3.7.5 Limitations in respect of unregistered persons

Pretty Nomble (3.7.4 above) sends Bisma a substantial account for bleaching of her teeth. May she claim this payment?
The Health Professions Act 56 of 1974 provides that no remuneration shall be recoverable in respect of any act specially pertaining to the profession of a registered person when performed by a person who is not registered under the Act to perform such act (s 59(1)).

Furthermore unregistered persons are prohibited from holding a professional appointment if such appointment involves the performance of any act which an unregistered person may not perform, excepting for persons employed by hospitals or similar institutions with a view to education and training (s 59(2)).

3.7.6 Professing to be a registered person or holder of certain qualifications an offence

In terms of section 40 of the Health Professions Act 56 of 1974 it is an offence to profess to be a registered person or holder of a qualification needed for registration. The section provides as follows:

Any person who is not registered in respect of any health profession, but –

(a) pretends to be so registered in respect of such profession; or
(b) uses any name, title, description or symbol indicating, or calculated to lead persons to infer that he or she is the holder of any qualification which by rule under the Health Professions Act 56 of 1974 is recognised by the relevant professional board as acceptable for registration in respect of such profession, but of which qualification he or she is not the holder; or
(c) uses any name declared by regulation to be a name which may not be used,

shall be guilty of an offence and on conviction liable to a fine or to imprisonment for a period not exceeding five years, or to both a fine and such imprisonment.

3.8 Unprofessional conduct

3.8.1 Inquiries by professional boards into charges of unprofessional conduct

The Health Professions Act 56 of 1974 provides that a professional board shall have power to institute an inquiry into any complaint, charge or allegation of unprofessional conduct against doctors or other professionals registered under this Act (s 41(1)). The professional board may, on finding such person guilty of such conduct, impose any of the penalties prescribed in section 42(1) (see 3.8.7). In practice the professional boards delegate their power of inquiry to a professional conduct committee (previously known as a disciplinary committee). Regulations have been promulgated regulating institution of an inquiry, including a preliminary inquiry, into alleged unprofessional conduct in detail. See GG 31859 of 6 February 2009, GNR 102. From these regulations it would seem that the so-called “preliminary committee of inquiry” has the power to institute a preliminary inquiry.

A professional board may, whenever it is in doubt as to whether an inquiry should be held, in connection with the complaint, charge or allegation in question consult with or seek information from
any person, including the person against whom the complaint, charge or allegation has been lodged (s 41(2)).

“Unprofessional conduct” is defined in the Health Professions Act 56 of 1974 as “improper or disgraceful or dishonourable or worthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or worthy (s 1).”

In essence a professional board is vested with the power to decide what is ethical and what is unethical with regard to medical practice. In Pretorius v SA Geneeskundige en Tandheelkundige Raad 1980 (2) SA 354 (T) the applicant, a medical practitioner specialising in ophthalmology, tested a woman’s eyes and also supplied the glasses, while there were optometrists in the town where the applicant practiced who could make the glasses on the applicant’s prescription. He also refused to give the woman a copy of the prescription. He was found guilty of improper conduct by the respondent’s disciplinary committee, and the finding was confirmed by the respondent. The applicant brought an application to the High Court for reversal, contending that the respondent erred by judging the applicant’s conduct as improper. The court rejected this submission and confirmed that the court could not consider the merits of the exercising of his discretion but could only decide on the question whether discretion had in fact been exercised. This case emphasises that the SAMDC is the final arbiter of what is improper conduct by a medical practitioner. The court contends that as members of the medical profession the members of the SAMDC have the necessary insight to decide what may be taken as improper conduct. (The disciplinary function of the SAMDC has of course been taken over by the professional boards, and this decision now relates to professional boards or their delegates.)

However, it is clear that professional boards have to exercise their power in respect of proper or improper conduct subject to the values entrenched in the Bill of Rights, which includes the right to just administrative action (see 1.9).

The HPCSA must, in consultation with a professional board, from time to time make rules specifying the acts or omissions in respect of which a professional board may take disciplinary steps. An important provision in the Act is that the powers of a professional board to inquire into and deal with any complaint, charge or allegation relating to a health profession, shall not be limited to the acts or omissions so specified (s 49(1)).

Such rules were promulgated and published in GG 29079 of 4 August 2006, R717, and they cover a wide range of forms of conduct, such as advertising and canvassing or touting; fees and commission; using a locum tenens; taking over patients; impeding a patient from obtaining the opinion of another practitioner or from being treated by another practitioner; professional secrecy; retention of human organs; certificates and reports and the information contained therein; issuing of prescriptions; exploitation, and a financial interest in hospitals.
3.8.2 Lodging a complaint

Regulation 2(1) of the regulations promulgated and published in GG 31859 of 6 February 2009, GNR 102 stipulates that complaints must be lodged in writing and be addressed to the registrar, the HPCSA or a professional board. When a complaint is addressed to the HPCSA or a professional board it must be submitted to the registrar (Reg 2(2)). The registrar must peruse and analyse all complaints received, categorise them according to their significance and seriousness, and record each complaint against the name of the respondent concerned as it appears in the register (Reg 2(3)(a)–(c)). So the ball is set rolling.

It is important to note that in terms of Regulation 4(1)(a) the registrar may, after receiving a complaint, call for further information or an affidavit confirming the allegations by the complainant. The information or declaration may (together with other information) later be submitted to a preliminary committee of inquiry for a preliminary inquiry.

3.8.3 The role of the ombudsman

The regulations (promulgated and published in GG 31859 of 6 February 2009, GNR 102) further stipulate that the registrar must refer complaints of minor transgressions and matters not falling under the jurisdiction of the HPCSA to the ombudsman for mediation or referral to the relevant authorities (Reg 2(3)(d)). The ombudsman is appointed by the HPCSA (Reg 1). “Minor transgression” means conduct which, in the opinion of the registrar or preliminary committee of inquiry, on the basis of the documents submitted to the registrar or such committee, is unprofessional, but of a minor nature, and does not warrant the holding of a formal professional conduct inquiry (Reg 1). Referring a complaint to the ombudsman is thus clearly intended to ensure that minor transgressions and matters falling outside the ambit of the jurisdiction of the HPCSA will not become matters for a formal professional conduct inquiry.

The ombudsman must therefore

(a) mediate in the case of minor transgressions referred to him or her for mediation in terms of Regulation 2(3)(d) with a view to resolving such matters (Reg 3(1)(a));
(b) refer cases that could not be resolved through mediation to the registrar for preliminary investigation (Reg 3(1)(b)); and
(c) refer matters not falling under the jurisdiction of the HPCSA to appropriate bodies or tribunals and inform the complainant of such referral (Reg 3(1)(c)).
3.8.4 Preliminary inquiry by a preliminary committee of inquiry

"Preliminary inquiry" is defined in the regulations (promulgated and published in GG 31859 of 6 Feb 2009, GNR 102) as "an inquiry held in terms of these regulations by a preliminary committee of inquiry to consider a complaint against a person registered in the register of the professional board concerned in order to make a determination on the appropriate manner of dealing with such a complaint". A preliminary committee of inquiry is a committee established by a professional board in
terms of section 15(5)(f) of the Health Professions Act 56 of 1974 for the preliminary investigation of complaints to make a determination thereon.

How is a preliminary inquiry initiated? The registrar must, after receiving a complaint, register the complaint and inform the respondent of the complaint (Reg 4(1)(b)). He must do this by sending the respondent a copy of the complaint together with copies of any other information or affidavits which he requested (see 3.8.2). The registrar must request from the respondent a written response within 40 working days from the date of receipt of the notification, or within such further period as the registrar may reasonably allow. A written response may consist of a written communication by the respondent that he or she invokes his or her right to remain silent (Reg 4(1)(b)(ii)).

Should the respondent fail to furnish the answer within the prescribed period, the complaint together with any further information or affidavits must be submitted to the preliminary committee of inquiry without the respondent’s written response (Reg 4(1)(b)(i)).

On receipt of the further information and written response, the registrar must submit the complaint, such further information and the written response to the preliminary committee of inquiry (Reg 4(2)). If no further information or written response is received, the registrar must record this fact and report it to the preliminary committee of inquiry (Reg 4(2)).

If the respondent failed to respond to the correspondence of the council, the preliminary committee of inquiry must, after due consideration of the matter referred to it in terms of Regulation 4(2), direct the registrar to issue a notice in writing to the respondent, instructing him or her to appear in person with his or her legal representative, if any, before the preliminary committee of inquiry at its next meeting to inquire why he or she did not respond to the council correspondence and to give his or her response to the complaint or exercise his or her right to remain silent. The preliminary committee of inquiry has the power to, after due consideration of the respondent’s explanation of why he or she failed to respond to the council correspondence, find that the respondent is in contempt of the HPCSA. The committee then has to do the following:

(1) Find the respondent guilty of contempt of the HPCSA, and impose a penalty. This may be one of the following:
   - a warning or reprimand, or both
   - a prescribed fine

(2) Order the respondent to submit, within such period as may be determined by the committee, his
or her written response to the complaint or a written communication to indicate his or her exercising his or her right to remain silent.

(3) Direct the registrar to confirm its decision in writing to the respondent, stating the reason(s) for the decision (Reg 4(4)).

If the respondent fails to attend the meeting of the preliminary committee of inquiry after having been duly notified in writing to appear before the committee, the committee may

(1) make a finding of guilty of contempt of the HPCSA and impose one or more of the penalties for contempt;
(2) order the respondent to submit, within such period as may be determined by the committee, his or her written response to the complaint or a written communication to indicate his or her exercising his or her right to remain silent; and
(3) direct the registrar to confirm its decision in writing to the respondent stating the reason(s) for the decision (Reg 4(5)).

A conviction of contempt of the HPCSA and the punishment imposed by the preliminary committee of inquiry takes immediate effect, but may be set aside by the High Court should the respondent appeal to such court in terms of section 20 of the Health Professions Act 56 of 1974.
Procedure for preliminary inquiry (from the lodging of a complaint to completion of the preliminary inquiry)

Complainant lodges complaint
- lodges the complaint in writing, addressed to the registrar, the HPCSA or a professional board.
- if a complaint is addressed to the HPCSA or a professional board, it must be submitted to the registrar.

Registrar notes complaint
- pursues, analyses and categorises the complaint.
- records the complaint against the name of the respondent concerned as it appears in the register.
- may call for further information or an affidavit that may be submitted to the preliminary committee of inquiry at a later stage.

Registrar informs respondent
- notifies the respondent of the complaint by forwarding to him/her:
  - a copy of the complaint
  - copies of further information or affidavits received
  - requests a written response from the respondent within 40 days (or such further period as the registrar may allow)

Respondent fails to provide a written response
- See “Procedure in the event of failure to respond to HPCSA correspondence”

Register submits complaint to PCI
- when the respondent fails to provide an answer within the prescribed time, the registrar has to submit the following to the PCI without the respondent’s written response:
  - the complaint
  - any further information or affidavits obtained.

PCI makes finding regarding complaint
- PCI may after due consideration of
  - the complaint,
  - any further information which may have been obtained
  - the lack of an explanation by the respondent
  - find that there are grounds for a professional conduct inquiry into the

PCI directs that an inquiry be held and that the registrar communicate its decision in writing to the complainant and the respondent and arrange for the holding of such inquiry

or

PCI may allow the respondent to pay an admission of guilt fine

Respondent submits a written response
- On receipt by the registrar of the further information and written response, s/he must submit the complaint, such further information and the written response to the PCI

PCI reaches a decision regarding complaint
- PCI may after due consideration of
  - the complaint
  - any further information obtained
  - the explanation by the respondent
  - make any of the following findings
Penny survives the first few weeks and is managing well. But time flies by and the 40 days are coming to an end. Penny is worried. What will happen if the doctor does not reply in writing?

Close your study guide and sit back. Think of what advice you could give Penny. Once you have decided we will continue.

Good, you are back. Penny need not have worried. Dr Verity Edelstein wrote back in time saying that she does not deny the allegations, but that she had good reasons for the complaint as Ms Fury "swore and shouted at her". Penny feels that Helga Fury's complaint is not very serious, and asks you again what she should do. You tell her to refer the complaint to the ombudsman for mediation. She does this.

Penny is relieved and starts cleaning up her office and arranging her pot plants. At first nothing happens ... but then the complaint is referred back to the registrar: the ombudsman could not resolve the dispute by means of mediation. Dr Edelstein will not apologise, and Ms Fury will not retract her complaint. No problem, Penny. It is now time to organise a preliminary inquiry.

The wording of the regulations indicate that a preliminary committee of inquiry has to make a finding after consideration of the complaint, any further information garnered (if any) and the respondent’s explanation of the subject matter under dispute, if such explanation had been furnished. There are thus different possibilities, depending on the information before the committee.

If the respondent **did in fact give an explanation of the subject matter of the complaint**, the preliminary committee of inquiry may make one of the following findings after due consideration of the complaint, any further information which had been obtained, and the respondent’s explanation:

1. **There are no grounds for taking further action on the matter** (Reg 4(7)). In this case the committee must note and accept the respondent’s explanation and give its reasons for so noting and accepting that explanation and direct the registrar to communicate its decision in writing to the complainant and the respondent stating the reason(s) for the decision.

2. **The respondent acted unprofessionally, but the conduct in question is found to constitute only a minor transgression** (Reg 4(9)). In this case the committee must determine, as a suitable penalty to be imposed, one or more of the penalties imposed for contempt of the Council (see above), and direct the registrar to formulate the charges in writing and communicate the charges and its decision to the respondent, stipulating that the penalty must be accepted or rejected within 14 days from date of receipt of the communication. If the respondent accepts the penalty, proof of compliance with such penalty must accompany the notice of acceptance to the registrar, and that penalty must be regarded as a penalty imposed by the preliminary committee of inquiry, whereupon the matter will be regarded as finalised. If the respondent rejects the penalty or no response is received by the due date, the registrar must arrange for an inquiry into the professional conduct of the respondent, and the charges so formulated and the penalty so rejected or not responded to may no longer be applied to the matter.

3. **There are grounds for a professional conduct inquiry into the conduct of the respondent** (Reg 4(8)). If the committee finds thus, it must direct that an inquiry be held and that the registrar communicate its decision in writing to the complainant and the respondent and arrange for the holding of such inquiry, or it may allow the respondent to pay an admission of guilt fine in terms of sections 42(8) and (9) of the Health Professions Act 56 of 1974. (See **3.8.7** with reference to an admission of guilt fine.)
If the respondent failed to provide an explanation on the subject matter of the complaint, the preliminary committee of inquiry may, after due consideration of the complaint, further information obtained, and lack of explanation by the respondent, decide, as in number (3) above, that there are grounds for a professional conduct inquiry (Reg 4(8)). The duties of the preliminary committee of inquiry are in this case similar to those set out in number (3) above. The regulations do not make it clear whether the preliminary committee of inquiry may in such a case make any other finding.

Apart from the procedure set out above for referral of a complaint to a preliminary committee of inquiry, the regulations provides that the registrar may refer the complaint directly to the preliminary committee of inquiry or the chairperson of such committee for instructions on the information required to complete a full investigation of the matter (Reg 4(1)(c)).

Also remember that the ombudsman must refer matters which he or she could not settle through mediation to the registrar for preliminary inquiry (see 3.8.3).

3.8.5 Inquiries into unprofessional conduct

As has been said, in terms of section 41 of the Health Professions Act 56 of 1974, a professional board is vested with the power to investigate alleged unprofessional conduct by practitioners. In practice disciplinary inquiries are undertaken by the professional conduct committee, since the council delegated this authority to the professional conduct committee (in terms of s 15(1)(f) of the Act).

Section 41A of the Act provides that the registrar may institute an inquiry into (amongst others) any complaint, charge or allegation of unprofessional conduct by a registered person (subs (5)). The registrar may, where necessary in order to establish more facts, appoint an officer of the professional board as an investigating officer for the purposes of this section (subs (1)). The task of the investigating officer is to establish more facts. This section bestows the investigating officer with certain powers in respect of gathering information and documents which may possibly relate to the matter, provides that the investigating officer may bring an application before a magistrate or judge for a search warrant, and regulates aspects in respect of executing such search warrant. The provisions of this section are interpreted strictly in order to ensure that the rights of a practitioner are not violated. An important provision of section 41A is that the registrar or investigating officer conducting an investigation in terms of this section, must compile a report on the investigation. If the report is compiled by the investigating officer, it must be submitted to the registrar (s 41A(8)(a)). If such a report reveals prima facie evidence of unprofessional conduct contemplated in this Act and no complaint or charge has been lodged or laid or allegation regarding the conduct in question has been made for the purpose of an inquiry, such report shall be deemed to be a complaint made for that purpose, and the registrar shall serve a copy thereof on the registered person concerned (s 41A(8)(b)(i)). If such a report does not reveal prima facie evidence of unprofessional conduct contemplated in this Act, the registrar shall serve a copy thereof on the registered person concerned. (s 41A(8)(b)(iii)).

A practitioner whose conduct is the subject of an inquiry in terms of section 41, shall be afforded an opportunity, by himself or herself or through his or her legal representative (ie a lawyer or advocate) of answering the charge and of being heard in his or her defence(s 42(2)). A professional board may take evidence, summon witnesses and require the production of certain documents (s 42(4)(a)).

In our discussion of preliminary inquiries we mentioned that, where the preliminary committee of
inquiry finds that grounds for a professional conduct inquiry (Reg 4(8)) exist, the committee shall order that such inquiry be undertaken. We also said that where the committee finds that the respondent acted in an unprofessional manner but that the conduct only constitutes a minor transgression, the committee indicated a fitting penalty, and the respondent rejected the penalty or the registrar did not receive any answer by the time of the due date (Reg 4(9)), the registrar has to arrange an inquiry into the professional conduct of the respondent. Regulation 5 of the regulations promulgated and published in GG 31859 of 6 February 2009, GNR 102 stipulates what the registrar must do after receipt of such order or such notice of rejection, or if the registrar does not receive such answer by the due date. He or she must then send a notice to the respondent, giving the date and time and place for the inquiry, including the charge sheet as compiled by the pro forma complainant. The regulations furthermore stipulate how the respondent should go about to request further particulars (Reg 7), provide for a pre-inquiry conference in order to determine the issues in dispute (Reg 8), and set out the procedure to be followed at such inquiry (Reg 9).

By now Penny is a regular visitor to your office. On the grounds of the documents brought before it the preliminary committee of inquiry found that Dr Edelstein was guilty, but that the offence was a minor transgression. The committee ordered Penny to put the accusations in writing and to inform Dr Edelstein of these accusations as well as the finding of the committee. She did that, and informed the doctor that she should accept or reject the penalty within 14 days of receiving said information. The doctor did not respond within the 14 days. What should Penny do now?

Once again you have to close your study guide and explain to Penny what she has to do. Be proactive and also tell her something about disciplinary hearings.

PS: It came out that Helga asked Dr Edelstein to give her a sick certificate for the 10 days before her visit to the practice. She pretended that she had a light cough and said she was not feeling well. When Dr Edelstein refused Helga tried to bribe her, and when that had no effect Helga swore and shouted at the doctor. The disciplinary committee found Dr Edelstein not guilty. Do you think the doctor may refuse to see Helga Fury again? Later in this study guide you will learn more about this matter.

### 3.8.6 Cognisance by professional boards of possible unprofessional conduct by practitioners that come to light during court proceedings

A court of law is obliged to inform the relevant professional board of any prima facie proof of unprofessional conduct by a practitioner that may arise during the court proceedings (s 45(2)).

If a practitioner, either before or after registration, has been convicted of any offence by a court of law, the professional board may take disciplinary action against such person if the board is of the opinion that such offence constitutes unprofessional conduct. The practitioner shall be liable on proof of the conviction to one or other of the penalties referred to in 3.8.7 below. Before imposition of any penalty such person shall be afforded an opportunity of tendering an explanation to the professional board in extenuation of the conduct in question (s 45(1)).
3.8.7 Penalties for unprofessional conduct

Any person registered under the Health Professions Act 56 of 1974 who, after a determination made by a preliminary committee of inquiry on minor transgressions or an inquiry held by a professional conduct committee, is found guilty of improper or disgraceful conduct, or conduct which, when regard is had to such person’s profession, is improper or disgraceful, shall be liable to one or more of the following penalties (s 42(1)):

(a) a caution or a reprimand or a reprimand and a caution;
(b) suspension for a specified period from practising or performing acts specially pertaining to his or her profession;
(c) removal of his or her name from the register;
(d) a prescribed fine (see GG 33385 of 23 July 2010, GNR 632);
(e) a compulsory period of professional service as may be determined by the professional board; or
(f) the payment of the costs of the proceedings or a restitution or both.

If an appeal is lodged against a penalty of erasure or suspension from practice, such penalty shall remain effective until the appeal is finalised (s 42(1A)).

Note that if a professional board on reasonable grounds is of the opinion that it shall impose a fine as determined by the Minister on conviction after an allegation of unprofessional conduct the professional board may issue an “admission of guilt” summons. The accused practitioner may then admit his or her guilt by paying the stipulated fine without appearing at said inquiry (s 42(8)–(9)).

A professional board may, if it deems fit, and subject to such conditions as it may determine, terminate any suspension before the expiry date, or on payment of the prescribed fee, restore to the register any practitioner’s name which has been removed from the register (s 42(7)).

A professional board may postpone the imposition of a penalty for a specified period, or impose a penalty as set out in (b), (c) or (d) above, but order that the execution of such penalty be postponed for a specific period. The professional board may determine the conditions for the postponement (s 43(1)).

The effect of suspension of a practitioner or removal of his or her name from the register is that such person is unable to practise his or her profession. The practitioner’s registration certificate shall be deemed to be cancelled until the period of suspension has expired or until his or her name has been restored to the register by the professional board (s 44). Should this practitioner continue practising, he or she will be subject to criminal prosecution by virtue of unregistered practising.

3.8.8 Performance assessment

Dr Doodle is a clever man and excellent diagnostician, but he is extremely slow – he is always at least three hours late for appointments and sends his accounts out three or four months after having seen his patients (he is obliged to send accounts out within a reasonable time – see 3.9 below). The registrar has received several complaints about his tardiness. How can the HPCSA ensure that Dr Doodle applies his considerable potential to the benefit of the community?
If a professional conduct committee finds that the evidence before it points to poor performance on the part of the respondent, it may impose practice restrictions and refer the matter, with its findings on poor performance on the part of the respondent, to a performance assessment committee (Reg 9(23) of the regulations promulgated and published in GG 31859 of 6 February 2009, GNR 102). (If the evidence before the committee indicates unprofessional conduct, the committee may also impose a penalty as set out above.) The aim with such referral to a performance assessment committee is to enquire into the performance of the respondent and make a determination on the appropriate management thereof. The committee orders the registrar to arrange the performance assessment.

Performance assessment thus takes place when a professional conduct committee found evidence of poor clinical and related performance during an investigation, or a pattern of such performance (see Reg 1).

On receipt of such directive the registrar must, in consultation with the chairperson of the professional board concerned, appoint a performance assessment committee and issue a notice addressed to the respondent stating the date and time when and the place where the assessment will be held, and the areas of poor performance identified by the professional conduct committee to be assessed by the performance assessment committee (Reg 10(1)).

At the conclusion of the assessment the performance assessment committee must make a determination on the appropriate management of the respondent’s poor performance and give directives to be adhered to by the respondent to improve on his or her performance within such period as may be determined by the committee. It must also require the respondent to submit such reports as may be determined by the committee to make a final determination on the performance of the respondent (Reg 10(4)).

The respondent must adhere to the directives given by the performance assessment committee, failing which the committee may direct the registrar to suspend the respondent from practising his or her profession until such time as he or she has fully complied with the directives (Reg 10(5)).

When the respondent has complied with the directives and the performance assessment committee has received the required reports, the committee must consider the reports to ascertain if the respondent has acquired the required skills to enable him or her to perform optimally in practising his or her profession (Reg 10(6)).

If the performance assessment committee, on the grounds of the reports submitted, is satisfied that the respondent has acquired the required skills to practise his or her profession with reasonable skill, it may lift the practice restrictions imposed by the professional conduct committee and finalise the matter (Reg 10(7)).

If the performance assessment committee, on the grounds of the reports submitted, is not satisfied that the respondent has acquired the required skills to practise his or her profession, the committee must determine the skills the respondent requires to be able to practise his or her profession with reasonable skill (Reg 10(8)).

3.8.9 Appeal against adverse disciplinary finding, and review

There are two types of appeal against a finding of a disciplinary committee:

(1) An appeal may be lodged to an ad hoc appeal committee appointed by the HPCSA (s 10). The
appeal committee may vary, confirm or set aside a finding of a professional conduct committee, or may refer the matter back to the professional conduct committee with such instructions as it may deem fit (s 10(3)). The respondent or the pro forma complainant may appeal to the ad hoc appeal committee against the findings or penalty of the professional conduct committee or both such finding and such penalty (Reg 11 of the regulations promulgated and published in GG 31859 of 6 Feb 2009, GNR 102).

(2) An appeal may be lodged to the High Court against a decision of the HPCSA, a professional board or a disciplinary appeal committee (s 20(1)).

As far as appeals in disciplinary matters are concerned, the courts will probably insist upon aggrieved parties appealing first to the appeal committee and only thereafter to the court (if they are still aggrieved). Courts generally require aggrieved parties to exhaust domestic remedies before approaching the court itself.

There has been uncertainty about the nature of the appeal to a High Court as provided in section 20(1). However, the Supreme Court of Appeal has now found in Health Professions Council of SA v De Bruin [2004] All SA 392 (SCA) that this appeal is an appeal in the normal sense of the word. It is therefore a rehearing on the merits, based solely on evidence or information on which the decision under appeal was made. The aim of such appeal is to ascertain whether the decision was correct. The court hearing the appeal must give due consideration to the fact that the HPCSA is the statutory custos morum of the medical profession, and since its members are mainly medical practitioners who know and appreciate the required standards of practice, this council has considerable advantages as opposed to a court of law when it comes to consideration and evaluation of the standards sought to be maintained. However, the Supreme Court of Appeal warns that, though a court of appeal naturally would be reluctant to interfere with a decision of a body such as the HPCSA, it should not hesitate to do so where interference is justified by the principles applicable to appeals. However, an appeal against a punishment (in contrast to an appeal against a finding) is subject to the long-held principle that the appeal tribunal may only interfere with an imposed punishment if the tribunal (or trial court) imposing the punishment made a material misdirection, or if the punishment may be seen as “startlingly inappropriate”. The principles set out in De Bruin were confirmed once again by the Supreme Court of Appeal in De Beer v Raad vir Gesondheidsberoep van SA [2006] 4 All SA 21 (SCA).

Apart from the statutory right of appeal an aggrieved practitioner may take the proceedings of a professional board on review to the High Court by virtue of the common-law powers of review of that court. Review procedure may be directed largely at the manner in which the disciplinary forum arrived at its findings. One could also say that the review process is aimed in essence on ascertaining whether the disciplinary forum committed a legally recognised procedural irregularity.

3.9 Practitioners’ charges

The Health Professions Act 56 of 1974 requires practitioners who in respect of any professional services rendered by them claim payment from any patient, to furnish the patient with a detailed account within a reasonable period (s 53(2)). A patient may, within three months after receiving an account, apply in writing to a professional board to determine what a reasonable fee would be (s 53(3)(a)). Before the professional board determines the amount the practitioner must be given an opportunity to submit to the professional board in writing his or her case in support of the amount charged. A claim referred to the professional board is not recoverable until a determination has
been made, and then only to the extent of the determination (s 53(4)). Apart from such action, the professional board may still take disciplinary action against the practitioner involved (s 53(5)).

Professional fees will be discussed in detail in 4.1.3 below.

3.10 Various provisions relating to medicines prescribed for or supplied to patients

3.10.1 Dispensing of medicines

Doctors, dentists and other registered persons have a limited right to compound or dispense medicines. In terms of section 52 of the Health Professions Act 56 of 1974 they may do so only on the authority and subject to the conditions of a licence granted by the Director-General of Health in terms of the Medicines and Related Substances Act 101 of 1965. A practitioner who has been thus licensed may, however, not keep an open shop or pharmacy. “Open shop” is defined as a situation where the supply of medicines and scheduled substances to the public is not done by prescription by a person authorised to prescribe medicine.

The Medicines and Related Substances Act 101 of 1965 sets several requirements and limitations:

(1) The practitioner must have successfully completed a supplementary course determined by the South African Pharmacy Council after consultation with the HPCSA, the Allied Health Professions Council of South Africa and the South African Nursing Council (s 22C(2)).
(2) A licence may be issued on the conditions prescribed by ministerial regulations (s 22C(1)(a)).
(3) An application fee is payable (s 22C(1)(a)).
(4) The licence will be valid for the prescribed period only and must be renewed by way of application in the prescribed manner, for which a fee is also payable (s 22D).
(5) The Director-General has the authority to suspend or revoke a licence on grounds such as failure to comply with a condition imposed (s 22E).

The issuing of dispensing licences to practitioners is governed by GN R510 GG 24727 of 10 April 2003. In terms of regulation 18 a formal application must be made to the Director-General.

In considering an application the Director-General must have regard inter alia to representations made by other interested persons as to whether a licence should be granted or not (Reg 18(5)(b)).

Regulation 18 contains strict requirements pertaining to the suitability of licensed premises, the keeping of proper records, labelling of medicines, and the like.

Note that “compounding and dispensing” as envisaged by the regulation does not refer to a medicine requiring preparation for a “once-off” administration to a patient during a consultation.

A licence issued to an applicant will be valid for five years. Application for renewal must be made periodically (Reg 20).

3.10.2 Generic substitution

In the pharmaceutical industry a distinction is drawn between “ethical medicines” (or “branded
The former concept refers to a medicine which is patented and may not be manufactured and marketed by anyone other than the holder of the patent. Once the patent has expired, however, other manufacturers may make and market similar products with the same active ingredients, provided they do so under a different trademark. The latter product is known as "generic medicine". Generic medicines may be considerably cheaper than the original, "ethical" medicine.

A pharmacist or dispensing doctor must inform all patients who present a prescription of the benefits of generic substitution, or, as the Medicines and Related Substances Act 101 of 1965 puts it, "substitution for a branded medicine by an interchangeable multi-source medicine" (s 22F(1)(a)). The pharmacist must also dispense a generic medicine instead of the medicine prescribed by the doctor, unless the patient has expressly forbidden substitution (s 22F(1)(b)). Such prohibition must then be noted on the script by the pharmacist (s 22F(2)). If a substitute is dispensed by the pharmacist, he must note the brand name or where no such brand name exists, the name of the manufacturer of that generic medicine in his prescription book (s 22F(3)).

A pharmacist may not dispense a substitute in the following three instances (s 22F(4)):

1. if the doctor has written in his or her own hand on the script the words "no substitution"
2. if the retail price of the generic product is higher than that of the prescribed medicine
3. if the product has been declared "non-substitutable" by the MCC (Medicines Control Council)

("Interchangeable multi-source medicine" is defined thus by the Act: "Medicines that contain the same active substances which are identical in strength or concentration, dosage form and route of administration and meet the same or comparable standards, which comply with the requirements for therapeutic equivalence as prescribed").

3.10.3 Commission on prescriptions

A medical practitioner, dentist or other registered person may not accept or obtain from a pharmacist any commission or other reward in connection with any prescription given by such medical practitioner, dentist or person. Contravention of this prohibition constitutes a criminal offence and may lead to disciplinary action by the professional board involved (s 57 of the Health Professions Act 56 of 1974).

3.10.4 "Bonusing" and "sampling"

The Medicines and Related Substances Act 101 of 1965 outlaws "bonusing" and "sampling". "Bonusing" refers to the supply of medicine "according to a bonus system, rebate system or any other incentive scheme" (s 18A of Act 101 of 1965).

"Sampling", again, is defined as "the free supply of medicines by a manufacturer or wholesaler or its agent to a practitioner. The prohibition does not, however, include the free supply of medicines for the purpose of clinical trials (s 18B of Act 101 of 1965).
3.11 Death of a patient undergoing a procedure of therapeutic, diagnostic or palliative nature

The death of a patient whilst undergoing a procedure of a therapeutic, diagnostic or palliative nature is not deemed to be a death from natural causes as contemplated by the Inquests Act 58 of 1959 or the Births and Deaths Registration Act 51 of 1992. The same is true where the death is the result of such procedure or any aspect of such procedure has been a contributory cause of such death (s 56 of the Health Professions Act 56 of 1974).

This means that a doctor who is of the opinion that any of the causes mentioned above was the cause of death (ie that it was not a natural death), may not issue a death certificate. In this case the doctor has to inform a police officer of his or her opinion (s 15(3) of the Births and Deaths Registration Act 51 of 1992). The police officer then has to act in terms of the provisions of section 3 of the Inquests Act 58 of 1959. This section prescribes that an investigation of the circumstances surrounding the death as well as a post mortem examination (if the body is available) has to be held. A death certificate shall only be issued after the investigation as to the circumstances of the death has been held, and the medical practitioner concerned is satisfied that the body (corpse) concerned is no longer required for the purposes of an examination mentioned in section 3 (s 17(1) of the Births and Deaths Registration Act 51 of 1992). (In study unit 9 we discuss criminal liability of a doctor in respect of murder and culpable homicide.)

3.12 Medical and health records

It stands to reason that it is of the utmost importance that doctors make detailed notes which they must keep, together with any other relevant documents pertaining to the treatment of their patients, in a file. This is both in their own interest and that of the patient. Notes in patient files are often of extreme importance when patients want to consult another doctor, or when there is a civil action for damages, or a disciplinary investigation by a professional board.

The National Health Act 61 of 2003 contains detailed provisions relating to the keeping of patient records by hospitals and other “health establishments”. (See for example s 13 on the obligation to keep record, s 14 on confidentiality of patient information, and s 17 on protection of health records. See also the discussion of Tshabalala-Msimang in 1.5 above on what the court said about the ratio behind the provisions in sections 14 to 17.) "Health establishment" is defined in such wide terms in the Act that it undoubtedly also includes the practice of private practitioners (see 2.3 above).

Specific mention should be made here of the right afforded doctors and other healthcare providers by section 16 to examine a patient’s health records for the following purposes:

(a) treatment, with the authorisation of the patient
(b) study, teaching or research, with the authorisation of the patient, head of the health establishment and the relevant health research ethics committee

However, if the study, teaching or research reflects or obtains no information as to the identity of the patient, the authorisations referred to in (b) are not required.

However, the Act provides in section 15 that a health worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person, health care provider or health establishment as is necessary for any legitimate purpose within the
ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user. (Personal information is personal information as defined in the Promotion of Access to Information Act 2 of 2000. Its scope is wide, and covers not only information about a person’s health.)

**3.13 Discharge reports**

Section 10 of the National Health Act 61 of 2003 requires health care providers to provide “users” (ie patients or clients) with a discharge report at the time of the discharge of the user from a health establishment. The report may be verbal in the case of an outpatient, but must be in writing in the case of an inpatient. These provisions seem to be designed primarily for hospitals and similar establishments, but as was mentioned in 2.3, the definition of “health establishment” is so wide that it clearly also includes private medical practitioners.

**3.14 Complaints by patients**

Patients may lay complaints about the manner in which they were treated at a health establishment. In the case of public establishments the complaint must be lodged with the official identified in section 18 of the National Health Act 61 of 2003, and in the case of private establishments, with the head thereof. Such a complaint must then be investigated in the manner set out in the section. It is not clear how these provisions will be applied in one-man practices.

**3.15 Duties of patients to comply with rules**

 Patients must adhere to the rules of health establishments. They must provide the doctor or other health care provider with accurate information about their health status, and must co-operate with the provider when making use of his, her or its services. Patients must treat practitioners and other health personnel with dignity and respect. If the patient refuses to accept recommended treatment, he or she must sign a certificate of release of liability (s 19 of the National Health Act 61 of 2003). (The section does not indicate what should be done if the patient refuses to sign such a certificate.)

**3.16 Rights of doctors and other health care personnel**

Health care personnel may not be unfairly discriminated against on account of their health status (s 20 of the National Health Act 61 of 2003). However, the head of the health establishment may, in accordance with guidelines determined by the Minister, impose conditions on the service that may be rendered by a doctor or other health care provider on the basis of his or her health status.

Every health establishment must implement measures to minimise injury or damage to the person or property of health care personnel working in the establishment, as well as in respect of disease transmission (see 4.1.1.2).

A health care provider may refuse to treat a patient who is physically or verbally abusive or who sexually harasses him or her.
ACTIVITIES

1. May Dr Arcangelo Noah in 3.7.4 above extract Mr Caries’ tooth? Discuss.
2. Discuss the disciplinary powers of professional boards in detail.
3. Define the concept of unprofessional conduct as contemplated in the Health Professions Act 56 of 1974.
4. List the duties of the ombudsman appointed by the HPCSA.
5. Discuss the limitations on dispensing of medicines by doctors.
6. Discuss the statutory provisions pertaining to generic substitution of medicines, the payment of commissions to doctors for prescribing certain medicines, and so-called “bonusing” and “sampling” in connection with the distribution of medicines.
7. Deletia’s name is removed from the register for medical practitioners after she was found guilty of unprofessional conduct by a professional conduct committee. She lodges an appeal against the finding and penalty imposed. Pending her appeal, she continues practising. Which one of the following statements is INCORRECT?

(1) She contravenes section 17(1)(a) of the Health Professions Act 56 of 1974.
(2) She makes herself guilty of the offence created in section 17(5) of the Health Professions Act 56 of 1974.
(3) She may continue practising pending her appeal.
(4) She may resume practising her career if her appeal is successful and her name is restored to the register by the professional board.

FEEDBACK

1. In section 17(1)(a) the Act prohibits practising of any health profession registerable under the Act by a person not registered in terms of the Act. In the scenario there is however no indication that Dr Noah is practising as dentist. However, it is not only prohibited for an unregistered person to practise as such, but also, barring a few exceptions, to perform an act deemed to be an act pertaining to a health profession which the practitioner is not registered for. Our case cannot fall under any one of the exceptions named in section 39(1)(a), (b)(i), (b)(ii) or (e). See 3.7.2. The acts pertaining to the dental profession have already been promulgated by regulation in GG 31958. The acts which Mr Caries wants Dr Noah to perform pertain to the dental profession – see 3.7.4 above. Does that mean that a medical doctor may never perform a dental procedure? Regulation 3 provides that Regulation 2 should not be interpreted in such a way that it prohibits a doctor who is not registered as a dentist from performing acts pertaining to the dental profession in the course of the doctor’s practice in an emergency or when a dentist is not readily available. Dr Noah would thus not be guilty of the offence created in section 39(2) by contravening section 39(1).

2. The disciplinary powers of professional boards are discussed in detail in this study unit. This question requires that you discuss everything covered under 3.8.1 to 3.8.9. When preparing for the examination pay attention to the headings in the study guide. Essay-type questions such as this one are often set in the same wording as the relevant headings. The study guide is not a jumble of loose thoughts; it is compiled with the aim of presenting the learning material in a systematic way, and headings play an important role in this regard. If you study the headings and know
what is discussed under each, the wording of a question will immediately indicate what you have to answer. You will also have a much better holistic view on the work. If a question reads: “Discuss preliminary inquiry by a preliminary committee of inquiry,” you have to discuss the material under 3.8.4, and if the question reads: “Discuss professional conduct investigations”, you have to discuss the material under 3.8.5.

3. Section 1 of an Act is often the section where concepts are defined. When one tries to interpret a piece of legislation, it is imperative to consult section 1 in order to understand precisely what each concept means. “Unprofessional conduct” is defined in section 1 of the Health Professions Act 56 of 1974 as “disgraceful or dishonourable or unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy”. If you are asked to give a definition, your answer should contain all the elements of the definition as given in the study guide in order to gain full marks. After all, a definition is a concise description explaining the essence of a concept in exact terms with as few words as possible. You therefore need not learn definitions by heart, but it would be easier than to try and formulate your own definition of a concept containing all the relevant elements.

4. Here you are not required to discuss anything, but merely to list the duties of the ombudsman. The ombudsman has to

   (1) mediate in the case of minor transgressions referred to him or her for with a view to resolving such matters;
   (2) refer cases that could not be resolved through mediation to the registrar for preliminary investigation;
   (3) refer matters not falling under the jurisdiction of the HPCSA to appropriate bodies or tribunals and inform the complainant of such referral.

5. See 3.13.1 above.

6. The sections covering this question contain learning material where short questions of approximately six marks or less may be asked. When doing revision for the examination you should always ask yourself what types of questions may be asked on a specific section. Some parts of the work are more suited to problem-type questions (eg where discussions on case law are needed), while other sections are more suited to essay-type questions or multiple-choice questions.

   See sections 3.13.2, 3.13.3 and 3.13.4 above. Would you be able to set some multiple-choice questions on these sections?

7. The correct answer is (3), since this is the statement that is incorrect. In order to answer this question you have to study 3.8.7 and then refer to 3.7.1 and 3.4. You will then see how things fit together.
### Glossary

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<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ad hoc appeal committee</td>
<td>A committee established by the HPCSA to hear appeals from a professional conduct committee of a professional board. It must consist of a person with knowledge of the law with at least 10 years’ relevant experience as chairperson, not more than two registered persons from the profession of the registered person whose conduct was investigated by a professional conduct committee of a professional board, and a member of the HPCSA appointed to represent the community. “Ad hoc” means “for a special or specific matter”.</td>
</tr>
<tr>
<td>admission of guilt fine</td>
<td>The fine that an accused practitioner who was issued a summons of admission of guilt can pay to prevent him or her from appearing at the investigation. The accused admits guilt by paying the fine.</td>
</tr>
<tr>
<td>&quot;admission of guilt&quot; summons</td>
<td>A summons that may be issued if a professional board, on reasonable grounds, is of the opinion that a fine (as determined by the Minister) will be imposed after a conviction on an allegation of unprofessional conduct.</td>
</tr>
<tr>
<td>“bonusing”</td>
<td>As defined in the Medicines and Related Substances Act 101 1965 – supplying of medicine according to a bonus system, rebate system or any other incentive system. Bonusing is prohibited by statute.</td>
</tr>
<tr>
<td>branded medicine</td>
<td>See “ethical medicine”.</td>
</tr>
<tr>
<td>bona fide</td>
<td>“Good faith”. Pronunciation: “BOW-nah FEE-day”.</td>
</tr>
<tr>
<td>custos morum</td>
<td>Custodian of morals. Pronunciation: “KOO-stows MOW-room”.</td>
</tr>
<tr>
<td>dispense</td>
<td>Prepare or mix medicine.</td>
</tr>
<tr>
<td>ethical medicine</td>
<td>Medicine which is subject to a patent and which may not be manufactured and marketed by anyone other than the patent holder. Also known as “branded” medicine.</td>
</tr>
<tr>
<td>generic medicine</td>
<td>See “interchangeable multi-source medicine”.</td>
</tr>
<tr>
<td>health establishment</td>
<td>As defined in the National Health Act 61 of 2003 – means the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services.</td>
</tr>
<tr>
<td>Health Professions Council</td>
<td>A statutory body governed by the Health Professions Act 56 of 1974. It is the successor of the old South African Medical and Dental Council (SAMDC), colloquially known as the Medical Council.</td>
</tr>
<tr>
<td>Council of South Africa</td>
<td></td>
</tr>
<tr>
<td>hospice</td>
<td>An establishment specialising in the care of dying patients. Narcotics (medicines that induce numbness and relieve pain) such as morphine are usually administered in controlled doses, and the patient is kept as comfortable as possible.</td>
</tr>
<tr>
<td>HPCSA</td>
<td>Health Professions Council of South Africa.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-----------------------------</td>
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</tr>
<tr>
<td>inpatient</td>
<td>Patient admitted to a health care establishment such as a hospital for at least one night’s stay for diagnosis or treatment.</td>
</tr>
<tr>
<td>interchangeable multi-source medicine</td>
<td>As defined in the Medicines and Related Substances Act 101 of 1965 – “Medicines that contain the same active substances which are identical in strength or concentration, dosage form and route of administration and meet the same or comparable standards, which comply with the requirements for therapeutic equivalence as prescribed.” Thus it is medicine containing the same active substances, but is manufactured and marketed under a different brand name than the original or ethical medicine. Also known as “generic medicine”.</td>
</tr>
<tr>
<td>locum tenens</td>
<td>Literally “person who keeps the place” – someone who temporarily acts as substitute for someone else, eg a practitioner who is contracted to work in another doctor’s practice while the latter is on holiday. Pronunciation: “LOW-koom teh-NEHNS”.</td>
</tr>
<tr>
<td>ombudsman</td>
<td>In this context a functionary appointed by the HPCSA to mediate cases of minor transgressions referred to him or her by the registrar. The ombudsman has special duties as set out in this study unit. “Ombudsman” is a Swedish word that in time gained international recognition.</td>
</tr>
<tr>
<td>open shop</td>
<td>For the purposes of s 52 of the Health Professions Act 56 of 1974, in respect of the right of a doctor, dentist or other registered person to dispense medicines – a situation where the supply of medicines and scheduled substances to the public is not done by prescription by a person authorised to prescribe medicine.</td>
</tr>
<tr>
<td>ophthalmology</td>
<td>The medical speciality concerned with the eye, diseases of the eye, and refraction deviations.</td>
</tr>
<tr>
<td>optometrist</td>
<td>A person practising the optometry profession. Optometry is concerned with examination of the eye and relevant structures in order to ascertain abnormalities in vision and the eye as such, and with prescription of lenses or other optical aids, or of visual exercises in order to ensure optimal vision.</td>
</tr>
<tr>
<td>outpatient</td>
<td>Patient who receives treatment in a health care establishment such as a hospital, but not admitted as inpatient.</td>
</tr>
<tr>
<td>palliative</td>
<td>Relieving the intensity or severity of symptoms (such as pain) without healing the underlying disease. Care in a hospice is a good example of palliative treatment. Palliative medicines are often used in treatment of diseases such as cancer, especially in the terminal phase.</td>
</tr>
<tr>
<td>performance assessment</td>
<td>A process during which a performance assessment committee investigates performance of a respondent and decides on proper management thereof. This happens when a professional conduct committee found evidence of poor clinical or related performance during an investigation, or a pattern of such performance.</td>
</tr>
</tbody>
</table>
performance assessment committee
An ad hoc committee established by a professional board to inquire into and make a determination on the clinical or related performance of a practitioner against whom a professional conduct committee found evidence of poor clinical or related performance, or of a pattern of such performance, at an inquiry.

preliminary committee of inquiry
A committee established by a professional board for the preliminary investigation of complaints to make a determination thereon.

preliminary inquiry
An inquiry in terms of regulations promulgated and published in GG 31859 of 6 February 2009, GNR 102 by a preliminary committee of inquiry, to consider a complaint against a person registered in the register of the professional board concerned, in order to make a finding on the appropriate manner of dealing with such a complaint.

prima facie evidence
Evidence that at first sight indicates a specific finding. Prima facie means “on the face of it”. Pronunciation: “PREE-mah FAH-key-ay”.

pro forma complainant
A person appointed by the registrar to represent the complainant who instituted a complaint against a registered person in connection with unprofessional conduct, and to bring the complaint before the professional conduct committee. “Pro forma” literally means “as a matter of form”.

professional board
A body established by the Minister on recommendation of the HPCSA with reference to a profession for which a register is kept in terms of the Health Professions Act 56 of 1974.

professional conduct committee
A committee (informally known as a disciplinary committee) to whom a professional board has delegated its authority to investigate a complaint, accusation or allegation of unprofessional conduct.

registrar
The registrar of the HPCSA.

SAMDC
South African Medical and Dental Council

“sampling”
As defined in the Medicines and Related Substances Act 101 of 1965 – the free supply of medicines by a manufacturer or wholesaler or its agent to a practitioner other than the free supply of sample medicines for the purpose of clinical tests. Sampling is prohibited by statute.

South African Medical and Dental Council
Predecessor of the HPCSA. Colloquially known as the Medical Council.

unprofessional conduct
As defined in the Health Professions Act 56 of 1974 – improper or disgraceful or dishonourable or unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy.
Contractual relationships

4.1 The contractual relationship between health care provider and patient

4.1.1 The contract between doctor and patient

4.1.2 Indemnity clauses

4.1.3 Medical fees

4.2 Mutual contractual relationships between doctors

4.2.1 Partner practice

4.2.2 Associate practice

4.2.3 Medical practice by means of companies

4.2.4 Practice in medical networks

4.2.5 Restraint clauses

4.2.6 Penalty clauses

Activities
Feedback
Glossary

Learning outcomes

When you have completed this study unit, you should be able to

- judge whether an agreement between doctor and patient is always required
- explain the basic content of the contract between doctor and patient
- discuss the basic legal principles pertaining to medical fees
- explain the nature of contractual relationships between doctors mutually
- decide whether a practitioner is entitled to protect him- or herself against competition, by way of a “restraint of trade” agreement

4.1 The contractual relationship between health care provider and patient

4.1.1 The contract between doctor and patient

4.1.1.1 General

A patient seeing a doctor in private practice enters into a contractual relationship with such doctor, and a patient going to a hospital for treatment enters into a contractual relationship with the private
or public hospital authority. In the latter case both the hospital staff, including the doctors, and the hospital authorities may incur liability for negligent conduct by the employees of the hospital. A person who wants to institute a contractual claim against a public institution, may do so in terms of the State Liability Act 20 of 1957. Section 1 of this Act provides that any claim against the state arising from a contract legally entered into on behalf of the state, is cognisable by a competent court.

4.1.1.2 Freedom of trade

Doctors in private practice are free agents or independent “contractors”, and can generally accept or refuse patients as they choose. In contrast, doctors who work in a private or public health care establishment are compelled to treat all patients admitted to the specific health care facility, such as a hospital. However, this does not mean that a health care provider must treat someone who is physically or verbally abusive or who sexually harasses him or her (see 3.16). The effect of the duty to treat all patients is fortunately also somewhat tempered both by common law and the provisions of section 20 of the National Health Act 61 of 2003 (see 3.16). By common law, there is a duty upon an employer to take reasonable measures to ensure that its employees work in safe conditions. A hospital authority accordingly should inform its employees duly on what steps to take so as to avoid contracting serious infectious diseases from patients. The hospital should also furnish its employees with the equipment reasonably required to avoid unnecessary health risks. Furthermore the patient has to adhere to the rules, treat the doctor with respect and dignity, and co-operate with the medical personnel (see 3.15).

A doctor who is available may neither ethically nor, it is submitted, legally, refuse to attend a patient who finds himself or herself in a dire emergency where his or her life or health will be seriously endangered unless he or she receives immediate medical treatment, unless there are compelling circumstances which prevent the doctor from acting. This is also true of doctors in private practice. The guidelines of the HPCSA on ethical practice stipulate that in cases of emergency doctors have to render healthcare within the limits of their practice, experience and competency. Should they not be able to do so, they have to refer the patient to a colleague or establishment where he or she may be treated. According to these guidelines doctors are also obliged to promote access to services where they cannot render the service themselves, by referring the patient to a suitable colleague or establishment where they may be treated, with the proviso that in an emergency the doctor is obliged first to render assistance to stabilise the patient, whereafter he or she may make a suitable referral. If a doctor-patient-relationship has already been established, the ethical rules of the HPCSA stipulate that the doctor has at all times to act in the patient’s best interests. The guidelines on ethical practice also stipulate that within the normal limitations of their practice, doctors have to be accessible to their patients when they are on duty, or make arrangements for accessibility when they are not on duty.

With reference to the legal position we would like to draw your attention to the provision in section 27 of the Constitution, in terms of which no one may be refused emergency medical treatment. Section 5 of the National Health Act 61 of 2003 makes it clear that a healthcare provider or a health worker may not refuse another person emergency medical treatment. A health care provider is someone providing health services in terms of any law, including the Health Professions Act 56 of 1974, the Nursing Act 50 of 1978 and the Allied Health Professions Act 63 of 1982. A “health worker” is a person, other than a health care provider, who is involved in the provision of health services to a user. These provisions are therefore applicable to both private practitioners as well as those in
someone else’s service, and confirm the common-law duty which in our opinion rests on these persons.

However, also keep in mind that the Schedule to the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 explicitly makes it an unfair practice in respect of health care to

- unfairly deny or refuse any person access to health care facilities or fail to make health care facilities accessible to any person
- refuse to provide emergency medical treatment to persons of particular groups identified by one or more of the prohibited grounds of discrimination such as race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth
- refuse to provide reasonable health services to the elderly

See in this regard 1.2 above.

### 4.1.1.3 Concluding a contract, and formal requirements

There are no formal requirements in respect of a contract between a doctor or hospital and a patient. The contract is concluded by consensus between the parties. In practice both private and state hospitals require patients to sign a written admission form, and to give written consent to surgery. In 5.2.2.2 we discuss specific legal provisions requiring written consent to certain interventions.

A contract may be concluded expressly or tacitly. In the case of the former it may be either written or oral. Doctors in private practice usually conclude a tacit agreement with their patients. If you have ever consulted a private doctor you will know that patients merely arrive at the consulting rooms (with or without an appointment), and that the doctor starts attending to your medical complaints and needs as soon as it is your turn to see him or her. This is how a tacit agreement is concluded in practice.

However, express agreements are often concluded, in particular where specialised procedures are involved.

### 4.1.1.4 The content of the agreement

An express agreement contains the terms on which the parties expressly agreed. It is of course not so easy to determine the terms of a tacit agreement, and in this case the implied or tacit terms of the contract will depend on the specific circumstances of the case. An implied contract normally entails that the doctor undertakes to examine the patient, diagnose the ailment, and treat the patient with the degree of professional skill, competence, care and judgment as would the average or ordinary medical practitioner in that specific branch of the profession (eg general practitioner, surgeon, gynaecologist). The doctor usually also undertakes to act in accordance with recognised, accepted and customary medical practice. Unusual procedures are not usually accepted as part of the implied terms of a contract, and must first be discussed with the patient.

On the other hand it is normally an implied term of a tacit agreement that the patient undertakes to pay a reasonable professional fee to the provider of the services rendered.

Normally the patient is entitled to any part of his or her anatomy that is removed during a medical
procedure such as surgery, but not to any X-rays or other diagnostic imaging material, reports or records taken or compiled by the doctor. The parties may of course mutually come to a different agreement.

An undertaking on the part of the doctor to examine the patient and to diagnose his condition does not amount to an undertaking on the part of the doctor to personally treat the patient. As is frequently the case, the doctor may decide to refer the patient to a specialist. In fact, if the diagnosis or treatment falls beyond the doctor’s training sphere or specialist field, the doctor is obliged to refer the patient to a suitable expert or to call in such person’s help. A separate agreement has to be concluded between the latter and the patient.

4.1.1.5 Normally no guarantee of a cure

By diagnosing and treating a patient a doctor does not guarantee that the patient will be cured of his disease (see the judge’s remarks in Buls v Tsatsarolakis 1976 (2) SA 891 (T) at 893; see also Thake v Maurice 1986 (1) All ER 497 (CA); Behrmann v Klugman 1988 (4) (discussed by Strauss SA in 1988 SA Practice Management 6). In Chalk v Fassler (1995 WLD, unreported) the judge remarked that no comparison can be drawn between an agreement to repair a car and an agreement to treat a patient medically. In the light of modern technology motor cars are generally repairable if reasonable care and skill are used; surgery (under discussion in the case), however, holds the risk of failure.

Should a doctor be so unwise as to expressly guarantee a cure, the patient might be able to claim damages for breach of contract in the event of the doctor’s failing to fulfil his undertaking.

4.1.1.6 Terminating the contract

The contract is terminated when the specific services have been rendered, for example when the treatment ends or the operation has been performed (Kovalsky v Krige (1910) 20 CTR 822). Once the treatment has commenced the doctor may not simply unilaterally withdraw from the agreement and abandon the patient. It is sometimes difficult to determine whether the agreed treatment involved a series of independent treatments (and agreements), or whether it must be taken as one ongoing course of treatment. Although a patient may at any time before the commencement of an agreed intervention retract his or her consent thereto, this would amount to breach of contract (see 4.1.1.7 below). The contract may also be terminated through mutual agreement, or when it becomes impossible for any one or both parties to perform in terms of the contract.

4.1.1.7 Breach of contract

If a doctor or hospital departs from the express agreement reached with the patient or fails to treat the patient in the manner tacitly agreed upon, the doctor or hospital will be guilty of breach of contract. Examples are where the intervention by the doctor differs from that agreed upon; a dentist furnishing a patient with ill-fitting dentures (Sutherland v White 1911 EDL 407); a doctor who has undertaken to perform an operation on a patient and then hands the patient over to another doctor (because of a golf appointment which the first-mentioned doctor has made in the meantime!) (Recsei's Estate v Meine 1943 EDL 277); or a doctor who has undertaken to forward for analysis a biopsy taken of a tumour in a patient's nose, and through negligence causes the biopsy to be lost (Hewat v Rendel 1925 TPD 679).
Doctors are expected to act with reasonable skill, competence, care and judgment, and therefore they are guilty of a breach of contract if they perform their duties negligently.

What are the consequences of breach of contract? The doctor may be denied the right to claim remuneration for his or her services. Patrimonial loss may also be recovered from the doctor, but not non-patrimonial loss. In *Administrator of Natal v Edouard* 1990 (3) SA 581 (A) a hospital authority was held liable for patrimonial damages resulting from a breach of contract in that the hospital doctors had failed to carry out an undertaking to perform a tubular ligation (sterilisation) on a woman; subsequently she fell pregnant and gave birth to a child. Non-patrimonial loss was not awarded. (See discussion of *Administrator of Natal v Edouard* 1990 (3) SA 581 (A) in 11.3.4). Since the doctor renders a personal service a court will probably not order specific performance.

The patient must honour his or her part of the agreement by keeping appointments and making himself or herself available for the specific intervention, and paying the doctors’ and hospital’s fees. A patient may be sued for payment of outstanding fees. However, a patient cannot be forced by a doctor or hospital to undergo the intervention agreed on, but can be held liable for the monetary loss (if any) caused by this failure. In practice this would normally mean that the patient could become liable for the fee which the doctor would have earned for the service less any sum he or she had actually earned or could reasonably have earned during the period set aside for the defaulting patient (see *Myers v Abrahamson* 1952 (2) SA 121 (C) at 127).

Specific provisions relating to the cancellation of appointments with medical practitioners were contained in the rules accompanying the tariff of fees for members of medical schemes, recommended annually by the SA Medical Association (SAMA), prior to 2003. It was provided that unless timely steps are taken to cancel an appointment for consultation, the relevant consultation fee may be charged. In the case of a general practitioner “timely” was defined as two hours, and in the case of a specialist 24 hours prior to the appointment. It was provided, however, that “each case shall ... be considered on merit and, if circumstances warrant, no fee shall be charged” (rule D of the general rules). Although this provision did not have statutory force, medical schemes and doctors generally applied it. It may be argued that the practice has become common law on the basis of “trade usage”.

4.1.1.8 An ex delicto claim due to negligence

A patient’s claim against a doctor for negligent treatment does not necessarily depend on proof of the existence of a contract. The patient may also sue on the basis of a delict having been committed (*Correira v Berwind* 1986 (4) SA 60 (Z)). Liability on the basis of delict is discussed in study units 10 and 11.

4.1.1.9 Adequate insurance against liability required

When section 46 of the National Health Act 61 of 2003 comes into operation, every private health establishment must maintain adequate insurance cover to indemnify a user for damages that he or she might suffer as a consequence of a wrongful act by any member of its staff or by any of its employees. In terms of the definitions in section 1 of the Act, user means a patient or certain other parties, such as a minor patient’s parent, or in the case of a person not able to take decisions, his or her spouse or partner, adult child or adult brother or sister, or other specified persons.

Health establishment is defined so widely that it also includes the practice of a private practitioner
Although most private hospital networks have professional liability insurance, it would become compulsory when section 46 comes into operation, and failure to comply with this provision will carry the risk of criminal sanction. Private hospitals will therefore be responsible for maintaining adequate insurance to cover staff (e.g., nurses), while medical practitioners who have patients in the hospital will be responsible for their own cover due to being independent contractors.

4.1.1.10 Private professional indemnity cover in South Africa

More than 26,000 medical practitioners in South Africa belong to the Medical Protection Society (MPS). This is not a profit-seeking organisation; it is a mutual organisation offering discretionary indemnity cover to its members (health practitioners) even in unusual circumstances. The MPS offers discretionary indemnity cover to its members where unfavourable decisions in respect of costs and damages have been made against the member in cases of professional negligence. The MPS will not (as some commercial insurance companies may do) refuse cover in respect of damages flowing from actions constituting a criminal offence (e.g., culpable homicide – see study unit 9).

In October 2011 the MPS pointed out in a media statement that the cost of clinical negligence claims in South Africa was escalating at an alarming rate. There was an exorbitant escalation in the total amounts of the claims, but also in the number of claims. In 2011 the MPS settled its highest claim against a member to date at the total cost of R24 million. The MPS aired its concern about whether the escalating cost and accompanying indemnity payments were sustainable, not only for practitioners but also for the wider healthcare economy.

4.1.2 Indemnity clauses

When a patient is admitted to a hospital for a procedure he or she is usually asked to sign documentation containing an indemnity clause.

An indemnity clause is a clause in a contract which excludes, limits or amends the legal liability of a party to the contract or the legal remedies to which the other party is entitled. The liability may arise from a contract, a delict or any other source. In principle clearly worded indemnity clauses are valid. A clause attempting to exclude liability for personal injury is not necessarily invalid. However, an indemnity clause that violates public interest will be null and void.

May a doctor, hospital or other healthcare provider protect him- or itself against liability for possible negligence in treating the patient or for some other form of malpractice by having the patient sign a waiver of claims prior to the intervention?

We here have to answer the question whether a specific clause in a contract between a healthcare provider and a patient is valid and enforceable. As was seen above, a doctor’s civil liability may arise both from a contract and a delict. Because this topic concerns the validity and enforceability of a specific term in a contract, we consider this type of clause, together with the question whether it could exclude any form of civil liability, in this study unit. We also have to keep this discussion in mind later when we consider delictual liability in study units 10 and 11.
A typical hospital admission form
An example of an indemnity clause, taken from the hospital admission form above

4.1.2.1 Indemnity of a medical practitioner

So far we have never had a case in our courts involving a waiver of liability by a patient for a potential claim against a negligent doctor. There is, however, an obiter dictum in a case, Edouard v Administrator, Natal 1989 (2) SA 368 (D) 385E, suggesting that a doctor could “contract out of liability” towards the parents of a child who was born to them after an unsuccessful sterilisation. But there is no indication in the judgment that this would be possible where there had been negligence on the part of the doctor. Our opinion, so far, has been that such contracts would probably be null and void because they would offend against public policy (or boni mores, in the sense of the juristic notions of society) and “unconscionable”, in the terminology sometimes used by the courts. A waiver by a patient indemnifying a doctor against liability for negligence, so it would seem, would be tantamount to a patient “licensing” a doctor to practise bad medicine.

In this connection it should be noted that there is nothing in our law preventing a patient after a claim – in legal terminology a “cause of action” – had arisen, to agree with the doctor or hospital to settle the claim or to abandon it in part or altogether, provided that the patient did so voluntarily and not under duress or undue influence. In South Africa the overwhelming majority of cases involving claims of patients against doctors or hospitals are settled out of court. It is common practice that patients who feel aggrieved and then institute claims, soon abandon the case because of the enormous costs of legal services.

4.1.2.2 Court findings in respect of indemnity of hospital authorities

At present many private hospitals in South Africa have a indemnity clause in their admission or consent forms which patients or their parents, guardians or curators have to sign before the patients are treated. The wording of these clauses differs substantially. In general the purpose of these clauses is to indemnify the hospital against harm that may befall the patient during his or her nursing, treatment or handling. Some of these clauses are defined very wide in order to indemnify the hospital and its personnel against claims arising from even gross negligence and reckless or intentional actions by the hospital personnel.

To our knowledge the finding of the High Court in Burger v Medi-Clinic Ltd 1999 WLD (unreported) was the first of this nature where a hospital was involved. The finding of the court a quo was in favour of the defendant, and the indemnity clause was enforced. The patient appealed against the ruling, and a full bench (three judges) of the same division of the High Court upheld the appeal. What is particularly
interesting about the Burger case is that the court of appeal has not ruled that such a disclaimer of liability by a hospital is null and void as such. The decision of the court of appeal merely focuses on its interpretation of the scope of the particular clause. The court namely found that the actions complained about and ascribed to the defendant are not covered by the ambit of the specific waiver clause.

In Afrox Healthcare Bpk v Strydom 2002 (5) SA 21 (SCA) an aggrieved patient who alleged that his treatment by hospital staff had been negligent, contended inter alia that the indemnity clause signed by him was contra bonos mores or, alternatively, that the principle of bona fides demanded that the existence of such clause and the implication thereof should have been pointed out to him pertinently by the staff, particularly in view of the fact that the hospital was “providing essential health services, which services are a basic right the [patient] is entitled to”. Mavundla AJ upheld these contentions and found that the clause was null and void.

The Supreme Court of Appeal set aside the judgment of the trial judge and came to the conclusion that the indemnity clause (or disclaimer) was indeed legally enforceable. The court came to the conclusion that inequality in the bargaining power of the parties to a contract does not in itself justify the conclusion that a contractual clause which is to the advantage of the “stronger” party necessarily is against the public interest. In the present case there was no evidence that the patient at the time of entering into the contract was in fact in a weaker position than the hospital.

Had there been such evidence, the court in Afrox might have reached another conclusion. In Napier v Barkhuizen 2006 (4) SA 1 (SCA) the court referred to the Afrox case and said that this case indeed confirmed that “inequality of bargaining power could be a factor in striking down a contract on public policy and constitutional grounds”.

Cartoon available at www.CartoonStock.com
The court also left open the possibility that an indemnity clause will not be upheld as defence against gross negligence, but there was no allegation of such degree of negligence in Afrox. The court further held that the indemnity clause did not offend against the values contained in section 27(1)(a) of the Constitution by which the right to access to health care services is guaranteed. Nothing prevents a private hospital from insisting on being remunerated for medical services or from imposing legally enforceable conditions for providing such services. The argument that the indemnity clause would promote negligence on the part of hospital staff does not hold water. Nursing personnel are at all times bound by their professional code and the statutory authority regulating their professional control body.

Moreover, the Appeal Court stated, the Constitution did not nullify the old established principle of stare decisis (whereby decisions of a higher court must be followed by courts with more limited powers, unless and until overthrown by the higher court). The Appeal Court also rejected the argument that the indemnity clause was contrary to the principle of bona fides (good faith). An abstract notion of that kind is not an independent or “free-floating” basis for setting aside a contractual clause; it is not an independent legal principle.

Finally, the patient could not rely on the allegation that he had not been apprised in advance of the indemnity clause. He did in fact know that the admission document signed by him contained provisions of the proposed contract between himself and the hospital, although he signed it without reading the contents. It is an age-old principle that someone who signs a written agreement without reading it, does so at his own risk and is bound by it—save for a few exceptional instances. There was no legal duty on the admission clerk to point out the indemnity clause to the patient in advance.

4.1.2.3 The Consumer Protection Act 68 of 2008 and indemnity clauses

The provisions of the Consumer Protection Act 68 of 2008 and particularly of sections 48 and 49 must be considered here. In terms of these sections indemnity clauses not only have to be pointed out to the consumer, but the latter must be afforded the opportunity to consider these terms of the contract. The application of this Act concerns service providers and consumers. A service provider is defined in such a way that it includes any person who promotes, supplies or offers to supply any service. Service is also defined so widely that it means any work or undertaking performed by one person for the direct or indirect benefit of another, as well as provision of information, advice or consultation. This applies, irrespective of whether the person promoting, offering or providing the services participates in, supervises or engages directly or indirectly in the service. These definitions are wide enough to include health care practitioners and health care establishments such as hospitals. “Consumer” includes a consumer of services, irrespective of whether the consumer was a party to the transaction for the provision thereof. A patient therefore qualifies as a consumer.

Section 48 deals with unfair, unreasonable or unjust contract terms. The section explains when a term will be regarded as unfair, unreasonable or unjust. For example, it provides that a contract term will be unfair, unreasonable or unjust if

- it is excessively one-sided in favour of any person other than the consumer
- the terms of the transaction or agreement are so adverse to the consumer as to be inequitable
- the transaction or agreement was subject to a term or condition
  - that was unfair, unreasonable, unjust or unconscionable
  - the nature and effect of which was not drawn to the attention of the consumer in terms of the requirements of section 49

70
Section 49 requires that a prospective consumer has to be informed in terms of the provisions of subsections (3) and (5) set out below of any provisions and conditions in the proposed contract that purports to

- limit in any way the risk or liability of the supplier or any other person
- constitute an assumption of risk or liability by the consumer
- impose an obligation on the consumer to indemnify the supplier or any other person for any cause

Section 49(2) applies in addition to subsection (1), and is of particular importance for our purposes as it deals with circumstances where the provision or notice concerns an action that is subject to any risk

- of an unusual character or nature;
- the presence of which the consumer could not reasonably be expected to be aware or notice, or which an ordinarily alert consumer could not reasonably be expected to notice or contemplate in the circumstances; or
- that could result in serious injury or death.

This may include a medical procedure. The service provider is here under a specific obligation to draw the consumer’s attention to the presence, nature and potential effect of the risk in terms of the provisions of subsections (3) to (5). In addition the consumer must have assented to that provision or notice by signing or initialling the provision or otherwise acting in a manner consistent with acknowledgement of the notice, awareness of the risk and acceptance of the provision.

Section 49(3) and (4) sets out how and in which form the above provisions have to be brought to the attention of the consumer, namely

- in plain language
- in a conspicuous manner and form that is likely to attract the attention of an ordinarily alert consumer, having regard to the circumstances

The time when the above provisions must be indicated to the consumer is also indicated in subsection (4). It must be done before the consumer enters into the transaction or agreement, begins to engage in the activity, or it is expected of the consumer to pay for the services, whichever happens first.

Subsection (5) provides that the consumer must be given an adequate opportunity in the circumstances to comprehend the provision or notice.

Had the above sections been applied to the circumstances in the *Afrox case*, the court would probably have come to a different conclusion. (This Act was not in operation at that time.) There would have been no uncertainty about whether the hospital (service provider in this case) was obliged to draw the patient’s (consumer) attention to the indemnity clause. It is also possible that an argument that the clause was unfair and unjust in the circumstances would have been successful.

An industry may be exempted from the provisions of the Consumer Protection Act by applying for exemption to the Minister. At the time of writing of this study guide it is not yet clear whether the medical profession or other branches of the healthcare industry have indeed done this, and if so, whether it would indeed be granted. If exemption is not granted it would bring about a radical change in the healthcare industry, since hospitals and medical practitioners will have to check their
service provision contracts very carefully to ensure that they do not contain any excessively one-sided provisions in favour of the hospital or medical practitioner. Hospital personnel will also have to be specially trained so that they know how to point out provisions in admission documents containing *indemnity clauses* to patients.

The Consumer Protection Act answers the question that was left hanging in *Afrox*, namely whether an *indemnity clause* could be applied to avoid liability for gross negligence. Section 51(1)(c) now provides that a supplier must not make a transaction or agreement subject to any term or condition purporting to limit or exempt a supplier of goods or services from liability for any loss directly or indirectly attributable to the gross negligence of the supplier or any person acting for or controlled by the supplier. Section 51(3) of the Act makes it clear that such a purported term or condition of a transaction or agreement, or notice to which a transaction or agreement is purported to be subject, is void to the extent that it contravenes section 53. If the health industry is exempted from the provisions of the Act, the uncertainty regarding the invalidity of a provision purporting to exclude liability on the grounds of gross negligence would arise again.

### 4.1.3 Medical fees

As we have mentioned under 3.9 above, a doctor is not entitled to charge any fee he wishes to charge, or which the patient is willing to pay. The fee must be reasonable. This is in line with the implied term of an agreement between doctor and patient in terms of which the patient normally undertakes to pay a reasonable professional fee for services rendered (see 4.1.1.4).

The Health Professions Act 56 of 1974 (s 53) provides that unless the circumstances render it impossible for him or her to do so, a medical practitioner must inform the patient or any person responsible for the latter’s maintenance (eg a parent) of the fee which he or she intends to charge before rendering any professional services. However, this must be done only where the doctor is so requested by the person concerned, or where the fee exceeds that usually charged for such service. In the latter instance, the doctor must also inform the person concerned of the usual fee.

The doctor must furnish a patient with a detailed account within a reasonable period. A patient may within three months after receiving an account apply in writing to the professional board to determine what a reasonable fee would be. The professional board may from time to time determine and publish the fees used by it as the norm for determining a reasonable fee.

However, the professional board has so far not determined a tariff scale. In determining what a reasonable fee is the professional board may be guided by the national reference price list compiled from time to time by the *Council for Medical Schemes*.

A claim referred to the professional board is not recoverable until a determination has been made, and then only to the extent of the determination. Apart from such action the professional board may still take disciplinary action against the practitioner involved.

A doctor (or other health care provider) who has rendered a service to a member of a medical scheme ("medical aid" as it is popularly known) or a dependant of a member must render to the member a detailed account – Medical Schemes Act 131 of 1998, section 59(1). The details required are set out in Regulation 5 of the Medical Schemes Act regulations (embodied in GN R1262 GG 20556 of 20 Oct 1999, as amended). Where an account has been rendered the medical scheme must pay within 30
days of receipt of the account to the member or doctor such benefit as is payable to the member or
doctor. Regulation 6 also makes provision for correcting of faulty accounts.

Cebile Rantaranta goes to Dr Penny Fortune for an examination. Dr Fortune does
many tests but finds nothing wrong with Cebile. She sends the account for the
consultation to Cebile as well as to Cebile’s medical scheme. The medical scheme
thinks the account is a bit high and pays Cebile only what they regard as a
reasonable fee for services rendered. She is angry and feels the medical scheme
should pay Dr Fortune directly, and for the total fee charged. Is the medical scheme
obliged to pay Dr Fortune directly?

There is nothing in the Medical Schemes Act or the regulations thereunder which compels a
scheme to pay benefits directly to a health care provider such as a doctor. No agreement exists
between the doctor and the medical scheme. If, however, a doctor’s fees are in accordance with the
tariff of benefits accepted by a scheme, the scheme will ordinarily pay the doctor directly. By law it
remains the responsibility of the patient to pay the doctor’s account, irrespective of the scale
according to which the doctor charges his fees.

Ms Rantaranta will have to accept the amount that the scheme paid out and pay in the
difference needed in order to pay the full amount claimed by the doctor. However, she may
apply in writing to the professional board for determination of an amount which it finds
reasonable.

In order to decide whether direct payment of a medical account will be made to the doctor
concerned, a medical scheme may be guided by the national tariff scale compiled by the Council for
Medical Schemes.

To determine what benefits a medical scheme is prepared to pay to members or their doctors all
schemes are compelled to make provision for certain minimum benefits (see s 29(1)(o) of the Medical
Schemes Act and Reg 8 under the Act). The current criterion for minimum benefits is the tariff of fees
charged by public (ie provincial) hospitals. However, medical schemes may offer enhanced benefits in
special options for members for which increased membership fees may be set.

Before 2003 different tariff structures were compiled by three different bodies, namely the Board of
Healthcare Funders (BHF), a body set up by medical schemes, the South African Medical
Association (SAMA), and the Hospital Association of South Africa (HASA). The BHF tariff structure
was considerably lower than that of SAMA, and medical schemes in general paid the BHF fee. If the
doctor charged a higher fee, the patient then had to “top up” the shortfall.

In 2003 the Competition Commission after a thorough investigation found that these tariff structures
were collusive and amounted to illegal price-binding. Health care providers such as hospitals and
doctors must accordingly determine their fees independently. In practice medical schemes now tend
to enter into direct negotiations with providers in order to determine the amount of a fee that it will be
prepared to pay directly to the service provider.

Medical schemes commonly require their members to pay specified cash levies in respect of
4.2 Mutual contractual relationships between doctors

We do not intend discussing the possible contractual relationships of a professional nature that may be entered into by medical practitioners in detail here. We merely draw your attention to a few aspects of practical importance.

4.2.1 Partner practice

In the past doctors who wished to practise jointly frequently formed partnerships, and many continue to do so. (Note that a partnership is not a company and it is not necessary to register the partnership as is the case with a company.)

Partners share profits as well as losses in accordance with an agreed ratio. One of the advantages of a partnership is that if a partner falls ill or takes a vacation, his income does not “dry up”, because he continues to share in the income generated by the other partner or partners. The Companies Act 61 of 1973 limits the membership of a partnership to 20. During 1996 the Minister of Trade and Industry agreed to exempt doctors, dentists, psychologists and members of supplementary health service professions from the limitation. The new Companies Act 71 of 2008 contains no similar provisions in respect of companies, so that there is no longer a limit to the membership of a partnership.

Two young doctors, Dr Keen and Dr Doolittle, wish to practise together and form a partnership with this in mind. At first Dr Keen finds Dr Doolittle’s placid disposition very soothing, but as time goes by a certain pattern emerges. Dr Doolittle regularly phones the practice to inform them of her latest personal crisis: her geyser has burst, her car has a flat tyre, her daughter has to say a rhyme at the eisteddfod, the hamster is experiencing a trance-like state, etc. She suffers the scourge of ill-health, and her sensitive constitution never misses an opportunity to succumb to the latest stomach bug going around, or to spoil her working day with food poisoning. Fridays at 10:45 she always gets the most awful migraines. Every school holiday she is totally exhausted and insists on going on leave (because, you have to understand, she has children of school-going age).

One hectic Monday morning Dr Doolittle again does not show up at the practice, while Dr Keen had been breaking his back since 6 o’clock in order to get through the long list of appointments. By 11 o’clock he phones Dr Doolittle on her cell-phone and gets the following message: “Good day. Dr Doolittle is not available. Do not hesitate to phone Dr Keen. In case of emergency please phone the golf club house at the Utopia Golf Club.” Dr Keen puts a cold compress on his forehead and rushes to a lawyer for advice.

From the example above it is clear that a partnership may also lead to problems. Relations may become strained if one of the partners does not pull his weight and the other partners feel that he is enjoying an unfair benefit from their hard work. Insolvency of a partner may also cause problems.
### 4.2.2 Associate practice

It is precisely because of the types of problems that Dr Keen in our scenario had to face that the custom arose for doctors to practise in a kind of free “association”.

Instead of constituting a partnership it is fairly customary in South Africa today that medical practitioners conclude agreements whereby facilities are shared (Strauss 77). This means that doctors do not form partnerships in which both profits and losses are shared, but enter into an agreement in terms of which each practises for his own profit, but they own certain facilities jointly, for example the consulting rooms and medical equipment, and also carry joint responsibility for the employment of staff such as nurses and receptionists.

In such agreements provision is also made for doctors in the “association” to take leave in an agreed order, and the others to then take responsibility for such a doctor’s patients. (Unless it is properly registered as a company – see 4.2.3 – such “association” is not a company.) The important characteristic, however, is that profits are not pooled, and therefore no separate estate arises. Doctors who practise in “association” also occasionally form companies to possess and control independent assets. For example, fixed property on which consulting rooms are situated may be owned by a company in which doctors are individual shareholders. A company offers advantages, for example the transfer of shares on retirement of a member of the “association”. Sometimes assets such as a holiday house are also purchased and controlled by a company in the interests of the members of the “association”.

The South African Medical and Dental Council (SAMDC) – the predecessor of the HPCSA – has ruled that if certain “less personal and more technical services” are controlled by doctors by means of companies, this does not amount to unethical conduct, provided that certain conditions are complied with (see Strauss 440).

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The partnership of Doolittle & Keen is dissolved, and Dr Keen enters into an association with the reserved and modest Dr Timidia Humbledore.

Dr Keen chooses the north-facing surgery closest to the reception area. He often peeps around the corner and whenever a new patient arrives he straightens his tie, goes out to greet the patient and chats a while. He also insists that his former receptionist, Petunia Tailfeather, be appointed. Dr Keen spoils Petunia every year on her birthday, Mothers’ day and Women’s day with outrageously expensive gift vouchers redeemable at different spas. Every year he also surprises her with a generous salary increase, without first discussing the matter with Dr Humbledore, who is struggling financially. Petunia prints all Dr Keen’s considerable brood’s projects for their outcomes-based education on the fancy new colour printer belonging to the practice. Whenever Dr H Dumbledore goes on leave or has a weekend free, Petunia refers all her patients to Dr Keen, who welcomes them with open arms, charm and whopping doses of sympathy. When Dr Keen goes on leave, Petunia would refer his patients to Dr Doolittle (who in the meantime has minimised her activities, seriously fearing burn-out). Dr H Dumbledore sadly watches as her struggling practice loses ever more patients.
Earlier we saw that medical practitioners can prevent certain problems associated with a practice in the form of a partnership by rather practising in association. This scenario shows that an associate practice has its own specific problems.

### 4.2.3 Medical practice by means of companies

In terms of the Health Professions Act 56 of 1974 corporate practice, that is constitution of a practice in the form of a registered company having limited liability, is generally prohibited for doctors. The Minister of Health may, however, on the recommendation of the Health Professions Council, exempt any juristic person or class of juristic persons from any of the provisions of the Act in order to enable such juristic person to practise a profession regulated by the Act. Conditions for such practice may be specified in the ministerial notice (s 54A).

The latest conditions for practise in corporate form are contained in GN R706, GG 15627 of 15 April 1994. These provisions stipulate that doctors, dentists, psychologists and persons rendering related health services may practise in corporate form, provided such company is a company with share capital and is incorporated as a private company in terms of the Companies Act 61 of 1973.

This company must comply *inter alia* with the following conditions as set out in the above government notice:

- The company’s memorandum and articles of association shall provide that all present and past directors shall be liable jointly and severally, together with the company, for the debts and liabilities of the company incurred during their term of office. This is an important point of difference between medical companies and typical commercial companies, as the latter are only liable up to the amount of their shareholding.
- Only natural persons registered in terms of the Health Professions Act 56 of 1974 and practising in terms of this Act, may be directors and/or shareholders of the company.
- Each shareholder of the company may practise only the profession for which he or she is registered.
- No person, whether a natural person or a juristic person, may share in the profits or income of the company unless he or she is a shareholder of the company.
- Every shareholder remains subject to the disciplinary powers of the HPCSA.
- If the company contravenes any of the conditions in this notice, such contravention will be deemed an act or omission of the shareholders or directors, in respect of which the HPCSA may take disciplinary steps.

Joint practice in this form has certain advantages for doctors. For example, it results in a greater measure of continuity as far as possession of practice assets is concerned. There could also be some tax advantages.

The provisions of the new Companies Act 71 of 2008 must also be kept in mind when this type of practice is considered.

In the Companies Act 61 of 1973 section 53(b) made provision for this type of company where persons wished to join forces in a company in order to practise a profession. These companies were incorporated as private companies with share capital. In the Companies Act 71 of 2008 this type of company has been replaced by “companies with personal liability”. There is no limit on the number of members of such company in terms of this latter act. The limit of 50 members for such companies
imposed in terms of the Companies Act 61 of 1973 thus no longer applies. The new companies are characterised by the term “Incorporated” or its abbreviation “Inc.” with which its name must end.

Since the regulation in terms of the Health Professions Act 56 of 1974 which regulates practice in corporate form still refers to the Companies Act of 1973, which has since been repealed, new regulations will have to be promulgated to exempt the new companies, now known as “personal liability companies” in the Companies Act 71 of 2008, from the limitations imposed in the Health Professions Act 56 of 1974 in respect of a medical practice in company form, and in particular the limitations as imposed in sections 17 and 39 of the latter Act.

The Companies Act 71 of 2008 (s 4(1)(b) of Schedule 5 to the Act) makes provision for transitional arrangements which apply in the interim. It stipulates that all companies originally incorporated in terms of section 53(b) of the Companies Act 61 of 1973 that are in existence when the Companies Act 71 of 2008 came into operation, will be deemed to be “companies with personal liability”.

4.2.4 Practice in medical networks

What we discuss here could perhaps be described as “collaborative practice”.

In the past decades several organisations, usually in the form of companies, have come into being to facilitate coordination of services in the field of primary health care. They can perhaps also be described as brokers in this field. Such a company may own and lease or sublease rooms to, for example, a clinic, a pharmacy and independent medical practitioners. This type of organisation has become known as a medical and health network.

Their objective is to facilitate the access of patients to a variety of medical practitioners, some specialised, and related health care providers conveniently located in one urban or suburban centre. The doctors are not employed by the company itself, but lease rooms and use the practice-management services offered by the company.

Such a company will then enter into agreements with medical schemes in terms of which the members of a medical scheme (or members who have selected a particular benefit option) will have access to health care providers at the centre at a reduced rate.

These agreements are known as capitation agreements. Such an agreement essentially means that the medical scheme pays the company a pre-negotiated fixed fee for arranging the delivery of specified medical benefits. Capitation agreements form an important part of “managed health care”, which is defined by the regulations under the Medical Schemes Act 131 of 1998 as “clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable”. Amongst other things the clinical necessity of particular procedures is critically assessed. Managed health care organisations must be formally accredited by the Council for Medical Schemes.

Doctors and patients are not always happy with the restrictions placed on treatment regimes as determined by the system of managed health care. However, managed health care decidedly results in lower medical costs.

Please note that doctors who practise at health care centres as described above may freely accept patients who are not members of medical schemes. Moreover, medical scheme members who wish
to make use of doctors not involved in the capitation arrangement, are quite free to do so, but will then not qualify for the reduced fees.

4.2.5 Restraint clauses

Because of the particular importance of this type of term in a contract between medical professionals, we urge you to carefully study the following.

4.2.5.1 Content

When a medical practitioner employs a professional assistant it often happens that the medical practitioner insists on including a condition in the agreement between them to the effect that upon termination of the agreement the assistant will not be entitled to practise for a certain period within the general geographical area in which the medical practitioner practises. Partners or associates also often come to an agreement that they will not compete with each other when one of them leaves the partnership or association. Also, when a medical practitioner sells a practice (or the goodwill thereof) the purchaser frequently insists on a similar condition in his or her favour.

The most acceptable name for these types of conditions is “covenant in restraint of trade”, but that is a cumbersome description, and they are also called bar clauses, restraint clauses or agreements in restraint of trade. For convenience sake we speak of a restraint clause.

4.2.5.2 Object of the clause

The object of a restraint clause is self-evident: protecting some or other interest, such as drawing power or goodwill. For example, a senior practitioner has through his skill and ardour established a practice with such success that he needs assistance. With a view to this he obtains the services of a young practitioner. Through being employed in this way the young practitioner is introduced to a large number of patients gained by the senior over a number of years, which represents considerable economic benefit. (Drawing power is not used in the sense of improper enticing of patients, but in the sense of attracting patients in the normal practising of the profession.)

In time the junior can also win the confidence of patients. This exposes the senior to the danger that the junior, on leaving, will take along a part of the practice. In order to diminish this risk, the senior endeavours to prevent the junior from practising in the same neighbourhood. The restraint clause simultaneously serves to prevent future competition, including the drawing of new patients. Identical considerations apply in the case of a partner, associate or seller of a practice being restrained by a restraint clause.

4.2.5.3 Conflicting legal principles/values

There are two conflicting legal principles or values involved in restraint of trade contracts, namely the principle/value of freedom of trade and the principle/value of sanctity of contracts. Following the common-law view our courts hold that the sanctity of contracts has to have priority over freedom of trade, although the latter must always be taken into account.
4.2.5.4 **Enforceability**

Since sanctity of contracts takes precedence over freedom to trade, a clause in a contract which restrains a party’s freedom to trade is in principle valid and enforceable. However, it is also a legal principle that contracts which violate public interest may not be enforced. A contract limiting freedom to trade will thus be unenforceable if it violates public interest. The test for enforceability of such clause will thus be public interest.

It may be assumed that restraining someone’s freedom to trade would probably be harmful to the public interest as well if the consequences thereof would be unreasonable. This would be the case where the person protected by the restraint (eg senior partner) has no practical interest in enforcing the restraint (eg where the senior partner himself stopped practising after dissolution of the partnership).

Reasonableness may be determined on the basis of four questions:

1. Does the party in whose favour the restraint clause operates own an interest that is worthy of the protection afforded by the clause?
2. Is this interest indeed affected by the party against whom the restraint clause is sought?
3. If the answer to (2) is in the affirmative, is restraint of one party’s freedom to trade in respect of period, area and prohibited activities necessary to protect the interest of the other party? In other words, does the interest weigh up both qualitatively and quantitatively against the interest of the other party in not being economically inactive and unproductive?
4. Is there any other facet of the public interest that requires that a restraint clause which is reasonable in respect of its effect on the relevant parties, should not be upheld, or a restraint clause that is unreasonable in respect of its effect on the parties, should indeed be upheld?

Each case is dealt with on its own merits.

4.2.5.5 **Partial enforceability**

A court is not limited only to find that a restraint clause is enforceable (or unenforceable) in its entirety; it may also decide that only a part of such clause is enforceable (or unenforceable).

4.2.5.6 **Finding on the basis of circumstances at time of application**

The court has to take into account the prevailing circumstances at the time when it is requested to enforce the restraint clause. (This is an important new position since in older decisions the courts took the view that whether the restraint is reasonable or not should be judged in the light of the circumstances at the time the contract was concluded.) However, the court could also take earlier and later circumstances into account.

4.2.5.7 **Burden of proof**

The onus to prove that enforcing the restraint clause will be contrary to public interest rests on the person averring that he or she is not bound by such a clause – normally the former assistant, junior partner or buyer of the practice.
4.2.5.8 Examples

Here are some examples from our case law of decisions on restraint clauses involving medical practitioners:

- Locum tenens restrained from practising as a general practitioner in Boksburg North or within five miles (about 8 km) thereof for five years. Upheld (Estate Matthews v Redelinghuis 1927 WLD 307).
- Seller of general practice restrained from practising within a radius of 10 miles (about 15 km) from City Hall, Cape Town, except as a specialist or employee of healthcare authority; no period stipulated – period therefore indefinite. Upheld (Weinberg v Mervis 1953 (2) SA 683 (C)).
- Professional assistant restrained from practising for two years within a radius of four miles (about 6 km) from employer’s consulting rooms in Durban. Upheld (Rogaly v Weingarts 1954 (2) SA 791 (D)).
- Partner leaving specialist ear, nose and throat practice restrained from practising in this specialised field for three years within a radius of 60 miles (about 90 km) from Durban City Hall. Upheld (Savage and Pugh v Knox 1955 (3) SA 149 (C)).
- Partner leaving general practice in Johannesburg restrained from carrying on general practice (but not specialist practice or as a healthcare authority employee) in Johannesburg for five years. Upheld (Hermer v Fisher 1960 (2) SA 650 (T)).
- Partner leaving general practice in Giyani restrained from practising in any capacity for three years in a radius of 50 km from practice. Period held to be unreasonably long. Scaled down to 12 months (Ntsanwisi v Mbombi 2004 (3) SA 58 (T)).

From the decisions quoted above – and many others in which persons other than doctors were involved – it is clear that an endeavour on the part of a doctor to protect himself with regard to an exceptionally large area and for an indefinite period, may lead to the court’s finding the restraint invalid, or limiting it to a reasonable extent.

If the restraint concerns a rare kind of speciality practised by only a few doctors in the country, however, a large area would not readily be held to be unreasonable. Enforcing such restraint clause could of course assist in ensuring that this rare speciality is made available over a larger area. On the other hand, when the court considers public interest it looks at availability of alternative similar services.

In Kleynstrü ber v Barr 2001 (3) SA 672 (W) the court found a restraint clause unenforceable, inter alia, because the service rendered by the first respondent for her new employer (second respondent) was unique and not available anywhere else in South Africa. She applied superior physiotherapy technology at the second respondent’s rehabilitation centre which was the only of its kind in the country.

4.2.6 Penalty clauses

In 4.2.5 we discussed contracts which limit freedom to trade. Sometimes there is a penalty clause attached to such contract.

For the purposes of this course a penalty clause may be defined as a provision in terms of which a party who acts in contravention of a contractual obligation is liable to pay a sum of money to the innocent party (the creditor), whether by way of penalty or as liquidated damages (see Conventional Penalties Act 15 of 1962.) Such a penalty clause is enforceable.
However, the innocent party is not entitled to claim damages in addition to the penalty sum; he may also not claim damages in lieu of the penalty sum, unless the particular contract expressly so provides.

If, upon the hearing of a claim of a penalty sum it appears to the court that the penalty sum is out of proportion to the loss suffered by the innocent party as a result of the breach of contract, the court may reduce the penalty to the extent it may consider equitable in the circumstances.

An example of a penalty clause attached to a restraint clause is found in *Weinberg v Mervis* 1953 (3) 863 (C). There the purchaser of a practice protected himself by way of a stipulation that if the vendor contravened the restraint clause, he would have been liable to payment of a fixed sum to the purchaser in respect of each breach. It is to be noted that the penalty clause should be as specific as possible.

### ACTIVITIES

1. Dr Promise Tshepiso, who performs an operation on Thembeni, guarantees to her that “the operation will be absolutely successful and you will be permanently rid of your complaint”. It turns out that the operation only partially cures Thembeni and that some of the problems still persist. Discuss whether Thembeni may sue Dr Promise for damages.

2. The usual fee for a particular type of operation performed by a specialist surgeon is R4 500. After performing the operation, the surgeon tells the patient that “it has been extraordinarily tricky” and charges a fee of R7 500. Discuss whether the patient can take any steps against the surgeon to cut his fee.

3. A patient is admitted to hospital. She is gravely ill and has to have an operation. On admission she was asked to sign a comprehensive document containing the standard conditions for admission to the hospital. One of the clauses in the document stipulates that the hospital is not liable for any harm suffered by the patient during her hospitalisation, even if the harm or damages would be the result of negligence or gross negligence on the part of the hospital staff. The patient indeed develops a very serious infection, and sues the hospital for damages. She *inter alia* alleges that she did not read the document presented to her on admission. The hospital *inter alia* raises the indemnity clause as defence. What are the defendant’s chances to succeed with this defence? Discuss.

4. Discuss the various ways in which doctors who wish to practise jointly can achieve this objective.

5. Dr Young, a young doctor, enters into a partnership with a senior and established doctor, Dr Oldknow. Dr Oldknow insists upon a clause being inserted into the partnership contract stipulating that should Dr Young leave the practice, she (Dr Young) will not be entitled to practise in an area with a radius of 75 km from the current address of the practice for a period of five years. Discuss the enforceability of such a clause.

6. Answer the following multiple-choice question. Medical practitioners in private practice are free agents or independent “contractors”, and can generally accept or refuse patients as they choose. Where a patient finds himself or herself in a dire emergency where his or her life or health will be seriously endangered unless he or
she receives immediate medical treatment, the situation is somewhat different. There are certain ethical and legal provisions that limit physician's freedom to accept or refuse patient at will. A practitioner in private practice ...

(1) must, in terms of the guidelines of the HPCSA on ethical practice, first stabilise a patient in an emergency situation, before referring the patient to a colleague or institution where the patient can be treated if the practitioner himself or herself is unable to treat the patient.

(2) must in terms of the guidelines of the HPCSA on ethical practice read together with the ethical rules of this body, always be personally accessible to a patient with whom he or she has already established a doctor-patient relationship.

(3) may refuse to provide emergency medical treatment to a patient who verbally abuses him or her.

(4) qualifies as a health worker as defined in the National Health Act, and as such may not refuse any person emergency medical treatment.

FEEDBACK

1. Mere acceptance of a patient by a doctor for treatment does not amount to a guarantee to cure the patient. Nor would encouragement of the patient by the doctor saying “not to worry, we’ll fix you” amount to a contractual guarantee. If, however, a doctor were to undertake expressly to achieve a specified result, it might perhaps be construed as a guarantee; failure to produce a successful result might then conceivably be seen as a breach of contract and result in a claim for damages.

2. Charging an excessive fee may land the doctor in trouble. First, if no advance warning was given to the patient, the latter may contend that there has been a tacit agreement between the parties that the doctor’s fee would not exceed the usual fee. If the fee charged is unreasonably excessive, the patient may lodge a complaint with the HPCSA, with the consequences as described in part 4.1.2 above.

3. In principle such clauses are regarded as valid. In terms of the finding in the *Afrox* case, the fact that the person who signed the admission form did not read it will not help such person to succeed with a claim. In the meantime the Consumer Protection Act 68 of 2008 came into operation, and it contains certain provisions in respect of indemnity clauses. The particulars in this regard are set out in 4.1.2.3 above. Should the provisions of this Act be applied, the clause will most probably be found unreasonable and therefore null and void. Also note the obligation imposed by the Act in terms of which the patient/consumer has to be informed of such clause. A clause excluding gross negligence is null and void in terms of the Act.

4. The forms of joint practice are (a) partnership, (b) associate practice or (c) practice in company form. In part 4.2 above the main advantages and disadvantages of these forms of practice are discussed briefly. We also discuss briefly the so-called “medical network” system.

5. South African case law has “mapped out” in considerable detail the validity of these “covenants in restraint of trade”. In principle they are enforceable unless unreasonably stringent or against the public interest. Depending upon whether the present clause involves general practitioners or specialists, the area of restriction as well as the period may be rather too restrictive. A court is entitled to “scale down” both the area and the term. You will have to reach a definite answer by looking at the basic principles described above in part 4.2.5 as well as the examples from case law.
6. The correct answer is (1).

Option (1): See 4.1.1.2. Note the various guidelines on ethical practice by the HPCSA and how they interrelate.
Option (2): Doctors need not always be personally accessible to their own patients.
Option (3): Although a doctor may refuse to treat a patient that abuses him or her physically or verbally in terms of section 20 of the National Health Act 61 of 2003, the Constitution does not contain a similar provision. The Constitution, as supreme authority, provides in section 27(3) that nobody may be denied emergency medical treatment.
Option (4): Read the phrase very carefully! Medical practitioners in private practice qualify as health care providers.

**GLOSSARY**

- **associate practice**: A form of practice where the associates do not form a partnership but enter into an agreement in terms of which each practises for his own profit, but they own certain facilities jointly, for example the consulting rooms and medical equipment, and also carry joint responsibility for the employment of staff such as nurses and receptionists.
- **Board of Healthcare Funders (BHF)**: An organisation with representatives from most medical schemes in South Africa as well as from neighbouring countries.
- **capitation agreement**: An agreement between a medical network organisation and a medical scheme in terms of which members of the scheme who accepted a specific benefit option will have access at a lower rate to practitioners at the centre owned or rented by those practitioners.
- **Council for Medical Schemes**: A statutory body established by the Medical Schemes Act 131 of 1998 to provide regulatory supervision over private healthcare funding by medical schemes.
- **covenants in restraint of trade**: Also called restraint clauses.
- **HASA Hospital Association of South Africa**: An industry association which represents the collective interests of the majority of private hospital groups and independently-owned private hospitals in the Republic of South Africa.
- **health care provider**: As defined in the National Health Act 61 of 2003 – a person rendering health services in terms of any Act, including the Health Professions Act 56 of 1974, the Nursing Act 50 of 1978 and the Allied Health Professions Act 63 of 1982.
- **health worker**: As defined in the National Health Act 61 of 2003 – a person who is not a health care provider, but is involved in the provision of health services to a user.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>indemnity clause</td>
<td>A clause in a contract with the object to exclude, limit or amend the criminal liability of the party to the contract, or the legal remedies to which the other party is entitled. The liability may arise from a contract, a delict or any other source. An indemnity clause which violates the public interest will be null and void. Also called a waiver.</td>
</tr>
<tr>
<td>medical network organisations</td>
<td>An organisation, usually a company, coordinating service delivery by health care providers in the area of primary health care, and concluding capitation agreements with medical schemes.</td>
</tr>
<tr>
<td>non-patrimonial loss</td>
<td>Adversely changing or disturbing the legally protected personal interests of a person without affecting his or her economic position.</td>
</tr>
<tr>
<td>obiter dictum</td>
<td>Statement made in passing; a non-binding remark on a legal aspect by a judge in a judgment. Pronunciation: “O-bee-têr DICK-toom”.</td>
</tr>
<tr>
<td>partner practice</td>
<td>A form of practice where the partners share the profits and losses in an agreed ratio.</td>
</tr>
<tr>
<td>patrimonial loss</td>
<td>Loss to the estate. This is the loss or reduction in value of a positive asset in someone’s patrimony, or the creation or increase of a patrimonial debt (a negative element of the patrimony). Patrimonial loss can also be defined as the detrimental impact on any patrimonial interest deemed worthy of protection by the law. If a plaintiff wants to claim damages from a contract, he must prove that he indeed suffered pecuniary loss, ie that he suffered patrimonial loss. This is ascertained by comparing the plaintiff’s estate after breach of contract with what it would have been had the breach of contract not taken place. Damages in breach of contract has the object to place the plaintiff (the innocent party) in the patrimonial position he would have been in if proper and timeous performance had taken place.</td>
</tr>
<tr>
<td>penalty clause</td>
<td>For the purposes of this course – a clause in terms of which a party who breaches a contractual obligation is liable to pay the innocent party a sum of money, either as punishment or as liquidated damages.</td>
</tr>
<tr>
<td>practice in company form</td>
<td>A type of practice in the form of a registered private company, now a company with personal liability; membership less than 50; directors and former directors jointly and severally liable with the company for debts incurred during their term of office; only doctors or other health services professionals registered in terms of the Health Professions Act 56 of 1974 may be shareholders or directors.</td>
</tr>
<tr>
<td>principle/value of freedom of trade</td>
<td>Principle in terms of which every person must be free to find fulfilment in the world of trade or another profession. As a contractual value it emphasises the individual’s right to engage without restriction in economic activity.</td>
</tr>
<tr>
<td>principle/value of sanctity of contracts</td>
<td>The principle from the law of contract in terms of which agreements concluded freely have to be honoured.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>restraint clause</td>
<td>In the context of medical law – a clause in a contract between practitioners in terms of which one party, on termination of the contract, may for a certain period not practise within the general area in which the other party practises. Also found in employment contracts and contracts concluded for the sale of a practice.</td>
</tr>
<tr>
<td>South African Medical Association (SAMA)</td>
<td>A non-statutory professional association for medical practitioners in both the public and the private sector; most doctors are members.</td>
</tr>
<tr>
<td>specific performance</td>
<td>Performance of that to which the parties to a contract agreed. The innocent party (ie the party not responsible for breach of contract) may demand specific performance, but the court has a discretion to refuse such order, eg when it would be difficult for the court to supervise specific performance. With specific performance the innocent party thus upholds the contract and demands performance of that which was agreed on. In reciprocal contracts, ie contracts where both parties have an obligation to perform simultaneously, the party demanding performance must perform itself, or offer to perform in terms of the contract before he or she may demand specific performance.</td>
</tr>
</tbody>
</table>
| stare decisis                 | The principle form the doctrine of precedent according to which previous findings by higher courts have to be followed by lower courts, unless the findings are repealed/overthrown by the higher court. Pronunciation: “STAR-reh deh-KEY-sis".
The legal basis of medical intervention

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Learning outcomes

When you have completed this study unit, you should be able to

- explain the basic legal principles that justify medical procedures
- judge whether a doctor has a legal duty, merely by virtue of his professional status, to treat a patient, or whether there are other factors which also play a role
- describe the legal requirements in respect of consent to medical interventions with regard to special categories of patients, such as minors or the mentally ill
- discuss the legal principles applicable when a doctor deviates from the intervention which he agreed upon with the patient
- explain the legal principles in respect of medical interventions in case of emergency where a patient is unable to give consent

5.1 Introduction

Any medical intervention entails a *prima facie* infringement of a patient's rights. For example, an operation entails that the patient is rendered unconscious, some part of the body is cut open, and then the wound is sewn together with needle and thread! What makes such an action different from the action of an attacker who hits someone over the head so that he is unconscious, and then sticks a knife into him? The good motive of the doctor alone surely cannot miraculously change the apparently unlawful/wrongful action into a lawful one. Our law acknowledges the patient's autonomy – the right to take decisions about your own body – and any intervention concerning the body to which no consent has been given or which otherwise cannot be justified, is in principle unlawful/wrongful.

The relationship between a doctor or hospital on the one hand and the patient on the other is normally contractual in nature. Consensus is usually required for a contract to come into being, and in the context of medical law this means that legally acknowledged consent normally is a prerequisite for a medical intervention to be lawful. There are also other grounds of justification for a medical intervention when consent is absent. These include:

- necessity and *negotiorum gestio* (both may apply in cases of emergency)
- statutory authority
- court order

One could thus say that a medical intervention is *prima facie* unlawful/wrongful if no ground of justification is present which excludes the unlawfulness/wrongfulness, and the most important ground of justification in this regard is consent. (We discuss consent and the general requirements for consent in 5.2 below.)

The rule that a medical intervention in principle requires consent means that a medical intervention is in principle unlawful/wrongful if consent is absent. (The situations where the other grounds of justification mentioned above find application are more the exception than the rule.) From a legal perspective the results of a medical intervention performed without consent would be that the doctor or possibly the hospital – depending on the relevant facts – may incur liability on the following grounds:

- breach of contract
- civil or criminal assault (violating the patient's physical integrity)
The doctor or hospital may also forfeit the right to charge a professional fee.

Consent entails three elements, namely knowledge, appreciation and acquiescence. The medical profession is based on specialised and complex knowledge which the patient does not (necessarily) have. Since consent presupposes knowledge and appreciation (understanding), a patient first has to be properly informed before his or her consent will be taken as legally valid. Therefore we could say that, in terms of the legal consequences, lack of informed consent (ie consent not based on relevant information) is the same as no consent. The requirements of knowledge and appreciation of course also presuppose that the person giving consent must have the necessary capacity to give consent that is legally valid. Normally consent is given by the patient him- or herself, but if the required capacity is lacking, certain substitutes may give consent in particular circumstances.

The process of providing information thus precedes the act of consent. We will first discuss the duty to inform as prerequisite for informed consent (5.3 below), and thereafter the rules governing substituted consent (5.4 below).

Although consent is the most important ground of justification for medical interventions, it is not the only one, as we indicated above. The other grounds of justification will be discussed later (5.5 below).

## 5.2 Consent

### 5.2.1 Introduction

The defence of consent to injury is of course relevant not only in the assessment of the lawfulness or unlawfulness/wrongfulness of medical treatment; it can be raised in a variety of other situations. This defence is expressed in the well-known maxim volenti non fit iniuria, which can be translated as "no injustice is done to him who is willing (or gives his consent)". This principle is an expression of the individualism which is characteristic of a society in which the freedom of the individual enjoys the highest respect. Each individual is considered to be free to work out his own salvation. Whilst the individual is protected against a violation of his interests by other persons, the law does not protect him against the consequences of his personal convictions or his own voluntary acts or heedlessness. Although the volenti maxim might appear to be generally applicable, it is subject to important reservations and restrictions.

### 5.2.2 General requirements for valid consent

In order to be legally valid consent to a medical intervention must

1. not violate the good morals of society (not be contra bonos mores)
2. be given in the proper form where such form is prescribed by law
3. be given voluntarily
4. be clear and unambiguous
5. be comprehensive
encompass all three elements of consent knowledge, appreciation, acquiescence be given by a person legally capable to give consent

We will now look in more detail at the requirements listed above. The last two are of particular importance in respect of medical law and will be discussed in more detail later.

5.2.2.1 Consent may not be contrary to the good morals of society (not be contra bonos mores)

Grant Tenderfoot is a starry-eyed student with an all-consuming desire to see the world. However, his dreams of exotic travels quickly fade when he thinks of his study loan: the deep dark pit into which all his hard-earned tips as a waiter disappear. Fortunately (or perhaps not?) for him he knows someone who knows someone who knows a certain Dr Choppitov. This doctor’s organisation, Tit for Tat Tissue Exchange, works as follows: you give him one of each set of organs and gonads coming in pairs; in exchange you receive a diamond or two. The organs are destined for the export market and only choice grade products get the stamp of approval. The organisation has no bad debts: the organ recipient pays cash on delivery. If not, he or she shall eventually pay an arm and a leg. Grant finds the idea of his organs being sent to other countries exciting and the compensation sounds very enticing. Besides, he argues, why would an aeroplane need two engines? Grant keenly agrees to this plan. Will the law acknowledge his consent and give effect thereto?

It is a general principle in our law that consent has to conform with the boni mores or good morals of society. An act therefore must be judged unlawful/wrongful if consent thereto violates the good morals. Good morals here mean the prevailing attitudes of society on what kind of conduct is lawful and what kind unlawful/wrongful. In this sense the notion of boni mores constitutes a juristic criterion.

For example, the law does not acknowledge consent to homicide (see 6.2.3.1), criminal abortion (8.2.11), reproductive cloning (7.6.4.3), reckless experiments (6.2.1) or unlawful organ donation (6.3.2.2).

5.2.2.2 Consent must be given in proper form where such form is prescribed by law

Have you ever been admitted to hospital? Can you remember whether you had to complete any forms when you had your wisdom teeth extracted? Have you ever donated blood, and can you remember whether you had to give written consent for the procedure? And your GP? Does he/she ask for your consent every time before examining you?

As a general rule no formal requirements are set for consent. Consent may be express, in other
words, oral or in written form, but is mostly rather implied by the patient’s behaviour. Express consent is consent given in words, either spoken or written. In *Stoffberg v Elliot* 1923 CPD 148 Watermeyer J set *express consent* for surgery as a requirement, but this supposition cannot be upheld. Although written consent would later facilitate proof of conduct, and is highly recommended in the case of serious interventions, it would be impractical for a doctor to obtain written consent from the patient before every treatment. Implied/tacit consent is the rule rather than the exception, and is effected by a request that a specific treatment or operation be applied or performed, or merely by tacitly submitting to the treatment.

If Kutlwano thus meekly makes himself at home on the examination table, a little more scantily dressed than usual, his conduct amounts to tacit consent to a routine examination.

Legislation sometimes requires *written consent*, as with sterilisation ([8.1.4](#)), surrogate motherhood ([8.4.1](#)), and removal or withdrawal of tissue, blood or gametes from a living person for medical or dental purposes ([6.3.2.1](#)). Regulations may also require consent to be in writing, as where a child consents to an operation ([5.4.2.1](#)) or a virginity test ([5.4.2.6](#)), and in the case of circumcision of a child ([5.4.2.7](#)), abortion ([8.2.9](#)) or donation of a gamete ([8.3.2.1](#)).

### 5.2.2.3 Consent must be voluntary

Consent may not be obtained through fear, violence (force) or fraud.

### 5.2.2.4 Consent must be clear and unambiguous

This requirement speaks for itself.

### 5.2.2.5 Consent must be comprehensive

Consent has to cover the transaction as a whole, including the foreseeable consequences and the material risks involved ([Castell v De Greef](#) 1994 (4) SA 408 (C) 425; *Christian Lawyers’ Association v National Minister of Health* [2004] 4 All SA 31 (T) 36).

### 5.2.2.6 Consent has to entail all three elements thereof, namely knowledge, appreciation and acquiescence

In *Christian Lawyers’ Association v National Minister of Health* [2004] 4 All SA 31 (T) 36 the court confirmed that consent is based on these three independent pillars.

All three have to be present to render consent legally valid. Knowledge does not necessarily encompass understanding or appreciation, and even though the patient may have knowledge and appreciation, it does not mean that he acquiesces (agrees or submits) to the intervention.

The medical profession is grounded in specialised and complex knowledge which the patient does not (necessarily) have. Since consent presupposes knowledge and appreciation, a patient first has to be properly informed before his or her consent will be taken as legally valid. Because informed consent is so important in medical law, we will discuss this requirement in more detail in [5.3](#).
5.2.2.7 Consent must be given by someone with legal capacity to give consent

A group of friends throws a wild bachelor party for the first of the group who is getting married. He is Tyron ("just call me Tyger!") Tappet. All of them consume far too much alcohol and eventually start behaving foolishly. The prospective bridegroom, Tyger, jumps over a railing of a building, fully confident that he will land softly, like a graceful cat, on his feet. He fractures a leg and sustains many open wounds. The entire intoxicated group sets off to the nearest emergency room. Can Tyger give consent for the surgical repair of the fractured leg?

Lack of the capacity to give consent implies that the elements of knowledge and appreciation are absent. Normally consent is given by the patient him- or herself, but if there is lack of capacity, specific substitutes may under specific circumstances give consent. Adults who are sober and sane are normally able to give consent. However, if a person is unconscious or in a state of delirium or shock or coma, or highly intoxicated or drugged, such person may not be able to legally give consent. Specific rules stipulate who may give consent to medical interventions, and in view of the importance of these rules we discuss them in more detail in 5.4.

5.3 Informed consent

5.3.1 Background

Application of the doctrine of informed consent is a fairly recent development in our case law. Although the duty to inform has been part of our law since the 1920s, the doctrine of informed consent was only pertinently acknowledged and accepted in Castell v De Greef 1994 (4) SA 408 (C). Van Oosten did an in-depth study of the law on informed consent, and published this work (based on his doctoral thesis) as Van Oosten FFW The doctrine of informed consent in medical law (Frankfurt am Main, P Lang 1991). The Constitution placed the importance of patient autonomy on a secure basis by expressly acknowledging the right to bodily and psychological integrity and, more specifically, the right of every individual to security in and control over his or her own body (s 12 of the Bill of Rights). The legislator soon followed and incorporated certain aspects of informed consent in the statute book (see eg the National Health Act 61 of 2003, the Children’s Act 38 of 2005 and the Mental Health Care Act 17 of 2002). The National Health Act 61 of 2003 contains important provisions on informed consent. These provisions in some respects extend the doctor’s duty to inform. For example, the Act requires that a patient be informed of the cost of every treatment option – an obligation that did not form part of our common law. However, in other respects common law offers more particulars in respect of informed consent than the cryptic provisions of the National Health Act 61 of 2003. A big deficiency in the Act is that it says nothing about the criterion to apply in order to ascertain which risks have to be disclosed to a patient.

The result of the different legal developments of recent times is that we now have a great number of requirements which often overlap and are not always reconcilable. Consequently some commentators are saying that we have now entered a “twilight zone” when it comes to applying the law in respect of informed consent. The challenge is to harmonise the different layers of the law
in order to find the correct balance (see Carstens P & Pearmain D *Foundational principles of South African medical law* (2007: 877). We can only hope that in due course the courts will shed more light on this issue.

### 5.3.2 The purpose and basis of the doctrine of informed consent

Informed consent is the embodiment of the idea that man is an autonomous being who can decide for himself or herself whether to undergo a specific medical intervention.

Immaculata Chichi is a very vain person who, to the knowledge of her doctor (Dr Goodwill Schweitzer) firmly believes in the inviolability of her appearance. On her right cheek, close to her well-groomed upper lip, there is a big black mole. She loves this saucy mole – or “beauty spot” as she prefers to call it. However, Dr Goodwill is not so taken up with this wicked growth and has already identified it as a pre-cancerous mole with a strong tendency to become malignant. He knows Immaculata well and also knows that she will definitely not agree to have it removed. Do you think he would be acting correctly if he tells Immaculata that he is only going to do a biopsy, while secretly planning to root out the entire growth?

Doctors do not have a professional right which licence them to intervene willy-nilly, even against the will of the patient. If a doctor acts in a way that to his or her mind is in the best interest of the patient, but this action is not in line with the patient’s convictions and wishes, the doctor is acting in a paternalistic manner. By requiring informed consent as prerequisite for a valid medical intervention our law rejects medical paternalism and protects the patient’s right of self-determination or autonomy. The important decision in *Castell v De Greef* 1994 (4) SA 408 (C) emphasises exactly this point. This view is also in line with the acknowledgment of the right to security in and control over one’s own body (s 12(2)(b) of the Constitution of South Africa, 1996) and the right to privacy (s 14). In *McDonald v Wroe* [2006] 3 All SA 565 (C) the court found that in the particular circumstances the patient had not been properly informed of the risk of nerve damage inherent in a dental intervention. The court added that subjecting the patient to surgery without her informed consent amounted to violation of her bodily integrity as guaranteed in section 12(2) of the Constitution.

The requirement of informed consent is not only aimed at protecting the patient’s right to self-determination, but also to promote rational decision-making by allowing the patient to weigh the pros and cons of an intervention before coming to a decision.

### 5.3.3 Nature and scope of a doctor’s duty to inform

#### 5.3.3.1 Common-law position

After thorough consideration of the common-law position Van Oosten concluded that it could be expected that a doctor give the patient a **general idea** in **broad terms** and **layman’s** language of the
If you have to undergo an operation, what type of risks would you want to be informed about? Do you think doctors should ask themselves what risks their colleagues would disclose, and then inform you accordingly? Or do you think they should let the need for information of the reasonable patient be their guideline? Should your values and needs, which you have made clear, play a role in determining which information a doctor should give you?

Although the doctor need not describe every possible complication that may arise (Lymbery v Jefferies 1925 AD 236 at 240), the patient must at least be informed of the serious and typical risks and dangers inherent in the intervention, for example, that it may be necessary to amputate the patient’s penis (Stoffberg v Elliot 1923 CPD 148), that pelvic fractures could occur due to electroshock therapy (Rompel v Botha 1953 TPA, unreported, quoted in Esterhuizen v Administrateur, Transvaal 1957 (3) SA 710 (T)), or that the dosage and method of application of X-ray treatment could cause mutilation, cosmetic changes, tissue necrosis and amputation of limbs (Esterhuizen v Administrateur, Transvaal 1957 (3) SA 710 (T) 721).

If the risk or danger inherent in an intervention is extremely uncommon or remote, the doctor cannot be held liable for failure to reveal such possibility to a patient. For example, in Richter v Estate Hamman 1976 (3) SA 226 (C) it was found that the risk of partial paralysis due to an injection known as a phenol block of the lower sacral nerves was so uncommon that the doctor cannot incur liability if he fails to inform the patient of this possibility. In Lymbery v Jefferies 1925 AD 236 the doctor sent the woman to a hospital for deep X-ray treatment for fibrosis of her uterus. The person administering the treatment was not a qualified X-ray operator. The woman sustained serious burns and suffered severe pain and discomfort. The court found (at 240) that the woman need not have been informed of the risk of burns, as this was a rare risk if the treatment was properly executed, and often was due to an unpredictable idiosyncratic reaction in a specific patient.

However, if uncommon or remote risks are serious (eg death, paralysis, blindness, deafness) it must as a rule indeed be communicated to the patient. If the patient enquires after uncommon or remote risks or dangers, the information also has to be given.

It is commonly acknowledged in our common law that the duty to inform is extended when the patient asks questions. In such instance the doctor has to answer all questions honestly and fully.
Is the doctor always obliged to give the same information to all patients in every circumstance? This would be nonsensical. Common law curtails the duty to inform in certain circumstances. The doctor namely has no obligation to inform in the following circumstances:

- The patient already has the requisite information.
- The patient waives his or her right to information expressly or tacitly (by implication).
- Disclosure is physically impossible in the circumstances.
- The damage caused by disclosure would be greater than the damage caused by withholding the information – the so-called “therapeutic privilege”.

The last instance, namely therapeutic privilege, entails withholding information which would normally have had to be revealed in order to comply with the doctrine of informed consent in circumstances where disclosure would not be in the patient’s best interests. (See SA Medical and Dental Council v McLoughlin 1948 (2) SA 355 (A) 366 and Richter supra at 232 G.) An example that has been mentioned in the literature is where a cancer patient would probably become so discouraged when fully informed about her situation that the efficacy or her treatment may be prejudiced. Another example is where a doctor has to give very bad news to a severely depressed patient with suicidal tendencies.

Dolores, an eighteen-year old matric girl is admitted to a psychiatric hospital with severe depression. She has made several attempts to commit suicide. It transpires that she was raped by her stepfather. During her stay in the psychiatric hospital the psychiatrist finds out that Dolores is pregnant and that her stepfather has AIDS. Is the psychiatrist obliged to disclose this information to her immediately.

A strong case could be made that the doctor could not by law be expected to give Dolores this potentially devastating news immediately. It does however not mean that the information may be withheld indefinitely. Her situation should be monitored carefully and she should be informed at an appropriate time while receiving the necessary support.

This defence has often been criticised (see Coetzee LC “A critical evaluation of the therapeutic privilege in medical law: some comparative perspectives” 2003 CILSA 268–288). In Castell v De Greef 1994 (4) SA 408 (C) 426 Ackermann J however confirmed that the duty to inform a patient “is subject to the therapeutic privilege”, but he significantly adds: “… whatever the ambit of the so-called ‘privilege’ may today still be”. The judge also referred (at 418) to criticism by several authors against therapeutic privilege, in particular the fact that it infringes on patient autonomy. Coetzee submits that this defence should only be applicable when all the requirements of necessity as ground of justification have been met (we discuss these in 5.5.3.1). He is of the opinion that even if all the requirements for necessity have been met, therapeutic privilege ought not to be applied if the medical intervention is against the patient’s wishes, or if the doctor has reason to believe, or knows, that the particular patient, if properly informed, will not consent to the proposed intervention.

Therapeutic privilege is accorded express but limited recognition by the Mental Health Care Act 17 of 2002 and the National Health Act 61 of 2003. Section 13(3) of the Mental Health Care Act 17 of 2002 provides that a mental health care provider may temporarily deny a mental health care user access to information contained in his or her health records if disclosure of that information is likely to seriously prejudice the user or cause the user to conduct himself or herself in a manner that may
seriously prejudice him or her or the health of other people. With respect to recognition of therapeutic privilege in section 6(1)(a) of the National Health Act 61 of 2003, see 5.3.3.2 below.

5.3.3.2 The National Health Act 61 of 2003
The provisions of chapter 2 of the National Health Act 61 of 2003 on informed consent in essence largely reinforced the common-law position as set out above. Thus, section 6 requires that the patient (or user) be informed of

- the benefits
- risks, and
- consequences

generally associated with an intervention.

The section goes further, and requires that the health care provider must inform the patient of the range of diagnostic procedures and treatment options generally available to the patient, as well as the benefits, risks, and consequences generally associated with each procedure. An additional extension of the duty to inform is that the health care provider has to inform the user of the cost generally associated with each diagnostic procedure and treatment option.

Note that section 6(1)(d) requires the doctor to inform the patient also of his or her right to refuse health services and to explain the implications, risks and obligations of such refusal.

While there was uncertainty in the past whether the doctor must inform a patient about the diagnosis, the National Health Act now provides in section 6(1)(a) that a healthcare provider has to inform a user of his or her “health status”. We submit that this provision indeed requires the doctor to disclose the diagnosis. The Act does not define “health status”, but it would seem as if the doctor cannot inform a patient of his or her health status without disclosing a diagnosis that had already been made. However, the provision allows for an exception to the rule, stipulating that the patient need not be informed of his or her health status in circumstances where there is substantial evidence that disclosure would be contrary to the patient’s best interests. This exception amounts to a partial statutory recognition of therapeutic privilege.

In a multicultural and multilingual country such as South Africa informed consent of course comes with its own challenges.

Mr Khuluma Zulu is eighty years old and hard of hearing. He has spent his entire life in a remote village at the foot of a green hill. He visits the humble hospital in his vicinity. Mr Zulu has never before in his life seen the inside of either a school or a hospital. Dr José Cigarro Cubano notices that the old man’s thyroid is greatly enlarged and will have to be removed. In halting English the doctor tries to explain this to Mr Zulu, who just stares at him in utter incomprehension. Dr Cigarro Cubano waves his arms and dramatically makes a cutting gesture across his throat. “Eish!”, Mr Zulu loudly exclaims. He jumps up and makes himself scarce, as quickly as his old legs could carry him. What does the Act say in this regard?

The Act provides that the health care provider must, where possible, inform the patient in a
language that the patient understands and in a manner which takes into account the latter’s level of literacy.

Illustration of the hypothalamus, pituitary gland and thyroid gland

5.3.4 Criterion for disclosure of risks

Have you considered the questions we asked above regarding the criterion that you would want the doctor to apply in order to determine which risks he should disclose to you when you have to undergo an operation?

Kantata (her stage name) Singh is a professional singer with dreams of international fame. She has got her mind set on Bollywood. She has a problem with her throat, and Dr Tremolo, an ear, nose and throat specialist, suggests an operation. It is a very delicate operation with many risks, some of them serious. There is also the risk of damage to the vocal chords, but this is so insignificant that most doctors don’t tell their patients, and the reasonable person would also not even be interested to hear about it, especially as some of the bigger risks deserve careful consideration. Should Dr Tremolo inform Kantata about this risk to her vocal chords?

The past four or five decades there has been heated debate internationally about what the criterion or standard should be for determining how much information a doctor should divulge to his or her patients concerning the risks involved in the proposed treatment or operation. There is good authority that the correct criterion is no longer that of the reasonable doctor, but rather that of material risk, a criterion based on patient autonomy. However, the Supreme Court of Appeal has not yet given a final decision on this matter.

In Richter v Estate Hamman 1976 (3) SA 226 (C) the plaintiff, a young married woman, had fallen on
a sharp edge of a chair and for the second time injured her coccyx. The defendant, an experienced neurosurgeon, gave her an injection known as a phenol block of the lower sacral nerves, which had most unfortunate consequences for the patient, namely, loss of control of the bladder and bowel, loss of sexual feeling and loss of feeling in the right leg and foot. The plaintiff alleged that the doctor had been negligent in failing to warn her of the possibility of these consequences. The court intimated that in certain circumstances a doctor is negligent if he fails to warn a patient of the possible risks attached to the proposed procedure. In principle his conduct should be tested by the standard of the reasonable doctor faced with the particular problem. According to the evidence of the doctors who testified during the trial, the likelihood of the plaintiff’s present complications occurring was extremely uncommon. In these circumstances, the court held, the fact that the defendant did not mention the possibility of such consequences to the plaintiff did not constitute negligence.

In the Richter case the court intimated that, in principle, a doctor’s conduct in informing a patient should be tested by the standard of the reasonable doctor faced with a particular problem: “In reaching a conclusion [on disclosure of risks by the doctor] a court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do” (our emphasis).

This standpoint was not followed by the full bench of the Cape Provincial Division of the Supreme Court in the important case of Castell v De Greef 1994 (4) SA 408 (C). The court held that a doctor is obliged to warn the patient consenting to medical treatment of a material risk inherent in the proposed treatment. The court defined “material risk” as follows:

<table>
<thead>
<tr>
<th>A risk is material if, in the circumstances of a particular case:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it, or</td>
</tr>
<tr>
<td>(2) the doctor is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.</td>
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This obligation is subject to the so-called therapeutic privilege. However, it was not necessary for the court to define the ambit of that privilege.

This criterion, the court said, is in accordance with the fundamental right of individual autonomy and self-determination. It also “sets its face against paternalism”. Although expert medical evidence would be relevant in determining the risks inherent in or as a result of a particular treatment (surgical or otherwise), and might also have a bearing on their materiality, this is not a question that is to be concluded on the basis of medical evidence alone. In the event of a dispute, the ultimate decision will be that of a court of law.

In his judgment in Castell Ackermann J was guided by legal developments in North America and Australia and on the European Continent. (As the judge pointed out, England still maintains the older “reasonable doctor” standard, which was reaffirmed in the case of Sidaway v Bethlem Royal Hospital Governors [1985] 1 ALL ER 635 (HL).) The facts of Castell are discussed briefly in 10.2.3.2 (d) below as this was a benchmark decision in South African medical law.
To return to the example of Kantata Singh who has to have an operation to her throat. If you apply the material risk criterion set down in *Castell v Greef* to her case, do you think Dr Tremolo should inform her as professional singer of the risk of damage to the vocal chords? The risk is so minimal that the reasonable person in the patient’s position would be unlikely to attach significance to it if informed thereof. But supposing Dr Tremolo knew that Kantata relies on her voice for her livelihood, and supposing also that Kantata indeed suffers serious damage to her vocal chords as result of the operation. It will not be difficult for her to convince the court that Dr Tremolo knew (or reasonably should have known) that this particular patient (the one and only Kantata), if warned of the risk, would be likely to attach significance to it.

In *Broude v McIntosh* 1998 (3) SA 69 (SCA) the Supreme Court of Appeal declined to express itself on the correctness of the judgment in *Castell*. In Broude’s case the plaintiff, B, was a medical doctor who in 1969 developed deafness and tinnitus (ringing or buzzing in the ear) and protracted bouts of giddiness. He was operated on in Germany and the operation left him permanently deaf in the left ear but alleviated the other conditions to such an extent that for 20 years he needed no further intervention. In 1989 there was a recurrence of vertigo and in 1991 B was operated on by the defendant, Prof M, an ear, nose and throat surgeon. The operation performed was a cochlear vestibular neurectomy (later described by the Appeal Court as a “designedly destructive operation” which has as its objective the severance of both the cochlear and the vestibular nerves). In close proximity to the vestibular and cochlear nerves is the facial nerve. (The *cochlea* is the shell-like spiral tube of the inner ear; the *vestibulum auris* is the entrance to the *cochlea*.)

Illustration of the inner ear
Following the operation there were indications that B suffered facial palsy (paralysis) on the left side. Some time later neurological tests showed a 100 per cent degeneration of the facial nerve, and another doctor consulted by B confirmed that the facial nerve was dead. B afterwards underwent corrective surgery overseas which restored some facial movement. B sued M for damages on the basis *inter alia* of assault and negligence.

The court found that M’s omission to inform B of the risk of leakage of cerebrospinal fluid during the operation was of no significance because the leakage was not proved to be causally related to the onset of the facial palsy. The trial court rejected B’s evidence that M had failed to inform him of the risk to the facial nerve and the availability of an alternative operation. The judge further found that B had been “at the end of his tether”, prior to the operation, had been looking at M to do whatever he could to alleviate his problems, and was amenable to whatever surgical intervention M recommended. The Supreme Court of Appeal upheld these findings, adding: “[I]t is also somewhat improbable that [Dr B] would have been disinterested in such matters given the fact that he was a medical practitioner with some knowledge of the anatomy of the area in which the operation was performed.”

Furthermore the Supreme Court of Appeal considered it a strange notion that this type of case should be juristically characterised as assault. (The *Broude case* is further discussed in 10.2.3.1 (a) below.)

In *Jacobs v Carpenter-Kling* (1998 TPD, unreported) a patient, J, sued Dr C, an ear, nose and throat surgeon, for damages on the basis of an alleged lack of information on the material risks inherent in an operation known as “functional endoscopic sinus surgery” designed to relieve the patient’s chronic sinusitis. Complications set in because of a leakage of cerebrospinal fluid. It necessitated further corrective surgery. Relying on *Castell* the court found that it was sufficient for a doctor to indicate the intended operation, the bodily parts on which the operation would be performed and the “danger areas” that might be affected, together with an indication that the required care would be exercised. On the facts before the court, J’s claim failed.

Illustration of endoscopic examination of sinus cavities
The Castell “material risk” criterion was confirmed by the court a quo in Oldwage v Louwrens [2004] 1 All SA 532 (C). In this case the patient experienced severe pain in the right leg. Having examined him the defendant, a specialist vascular surgeon, diagnosed his condition as a blockage in the arteries responsible for blood supply to his leg (claudication). One of the iliac arteries was completely blocked off. He recommended a bypass operation. During this operation the blood would be re-routed along substitute tubing to the lower part of the leg, by-passing the blocked arteries. The defendant subsequently performed the bypass operation. The patient later underwent a laminectomy at the hands of a neurosurgeon with a view to relieving pain in his back caused by degeneration of a disc in his spine. After the latter operation he started experiencing pain in his left leg, and the neurosurgeon established that he suffered claudication (pain caused by poor circulation due to blockage of arteries) in his left leg.

In the civil case that followed the court found that the defendant-doctor wrongly diagnosed the patient with claudication instead of a degenerated disc in his spine. Moreover Yekiso J found that the patient had not been properly counselled prior to the operation of other options regarding treatment or of the material risks (such as claudication as a result of “steal syndrome”) attendant on the proposed operation. There was, accordingly, no proper informed consent, and the surgeon’s conduct constituted assault. The judge emphasised the importance of patient autonomy.

The case went on appeal to the Supreme Court of Appeal, where the appeal was upheld – see Louwrens v Oldwage [2006] 1 All SA 197 (SCA). The Supreme Court of Appeal again (see Broude’s case above) refrained from giving any unequivocal indication on the correctness of the materiality criterion applied in Castell v De Greef by the full bench. “Steal syndrome” may occur as a result of the bypass operation if blood destined for the left leg is diverted to the right leg, and this diversion causes claudication in the left leg. The court merely held that the risk of “steal syndrome” occurring (with the resultant claudication) was so negligible – around 2% – that it was not unreasonable for the defendant not to mention it. The court also accepted evidence that if “steal syndrome” does occur, it can be rectified by a minor operation.

In McDonald v Wroe [2006] 3 All SA 565 (C) the Cape High Court, with reference to Castell, confirmed the criterion of materiality as the standard to be applied. In this case a woman (the
plaintiff) visited the defendant (a dentist) in connection with problems with her wisdom teeth. He advised that three of her impacted wisdom teeth be extracted. He later extracted the teeth while she was under general anaesthesia. She suffered permanent damage to her lower alveolar nerve, and instituted a claim against the dentist. The operation was difficult and potentially dangerous because the root of one of the extracted teeth lies very close to the lower alveolar nerve canal.

Illustration of some of the nerves in mouth

Illustration of facial nerves
The court nonetheless found that the plaintiff could not prove on a balance of probabilities that the defendant did not have the necessary skill to perform the operation, and thus the defendant was under no obligation to offer to send the plaintiff to a specialist surgeon. The defendant conceded that he did not warn the plaintiff of the risk of permanent nerve damage, but alleged that this omission was not the cause of the damage, because she would probably still have undergone the operation at a later stage, even had she been informed of the risk. The court found that, although the plaintiff might have undergone the operation at a later stage had she been properly informed, she would in those circumstances rather have had it performed by a specialist surgeon. The question was whether the plaintiff had proven that she would not have suffered permanent nerve damage had the operation been performed by a specialist surgeon. The court found (at 574) that the probability of such damage would then have been smaller and that the defendant thus was causally responsible for the plaintiff’s damage.

It is disappointing that the Supreme Court of Appeal missed two opportunities to make an express finding on the correct criterion to apply when determining which risks have to be disclosed. In our opinion doctors in the meantime have to be guided by the criterion of material risk as set out in the well-reasoned Castell judgment.

5.3.5 Who has the duty to inform?

In terms of common law the duty to inform rests in principle on the doctor, and normally the doctor who will perform the intervention.

The health care provider bears the duty to inform in terms of section 6 of the National Health Act 61 of 2003. The Act defines “health care provider” as a person providing health services in terms of any law, including in terms of the Health Professions Act 56 of 1974, the Allied Health Professions Act 63 of 1982, the Nursing Act 33 of 2005, the Pharmacy Act 53 of 1974 and the Dental Technicians Act 19 of 1979.

5.3.6 Who must be informed?

Normally the patient him- or herself has to be informed. However, where the patient is incapable of consenting, the person who consents on behalf of the patient has to be informed. The persons who may consent on behalf of a patient in terms of the National Health Act 61 of 2003 are discussed in 5.4 below.

5.3.7 Tests, including HIV/AIDS tests, and informed consent

Doctors or other health personnel who take urine or blood specimens from patients who seek medical advice or treatment need not ordinarily inform the patient what these specimens will be tested for – unless the patient insists on being told – because the taking of a urine specimen involves no risk at all, and in the case of a blood specimen, negligible risk only. If, however, the taking of a blood specimen for purposes of testing it for HIV is proposed, it will not be sufficient merely to tell the patient that it is “for HIV or AIDS testing”. Such a test should be preceded by adequate counselling. See C v Minister of Correctional Services 1996 (4) SA 292 (T). In this case the court held that consent must be informed. There can only be consent if the person appreciates
and understands what the purpose of the test is, what an HIV-positive result entails, and what the probability of AIDS occurring thereafter is.

Should the test for HIV be positive, a legal obligation would in our opinion arise for the doctor, or other health care worker involved, to inform the patient and to counsel him or her properly, considering the fact that AIDS is a deadly, incurable and infectious disease.

Both pre- and post-HIV test counselling after the result was given to the patient should be carefully documented by the doctor. Naturally the patient’s written consent must be based on proper information given in the person’s mother tongue.

Concerning HIV testing it should be mentioned that the Employment Equity Act 55 of 1998, section 7(2), prohibits such testing of an employee unless the Labour Court has determined the justification thereof. The legislature’s intent with this subsection and its exact scope became subjects of serious debate.


In a decision by the Labour Court in Rand Water Board v SAMWU (Nov 2001), the court emphasised the need for informed consent by patients. The court ruled that HIV testing of employees was permitted for a restricted time under the following conditions:

(1) Testing is done at all times on a voluntary basis and with the informed consent of the employee to be tested.
(2) Testing will not be requested as a condition of employment, promotion and/or any other benefits.
(3) Testing will not be a job requirement.
(4) No prejudicial inference will be drawn from a refusal to submit to testing, nor will the applicant be informed or request to be informed of employees who have undergone testing.
(5) Testing will only be done after pre-test counselling, and will be followed by post-test counselling.
(6) The contractors conducting the testing will at no time reveal the results of the test to anyone but the employee.
(7) The contractors will be required to sign a confidentiality agreement.
(8) The result of any testing will not be made known to any decision maker required to decide on any employment policy or practice concerning such employee.

In January 2003 the Cape Town Labour Court in Irvin & Johnson Ltd v Trawler and Line Fishing Union 2003 (3) SA 210 (LC) held that “anonymous and voluntary” HIV testing did not fall under section 7(2) of the Employment Equity Act. Voluntary testing in the workplace could therefore be done without the employer first seeking the court’s permission. The section only prohibited HIV testing that was compulsory and intended to discriminate against employees.

5.4 Capacity to give consent

5.4.1 General position and substituted consent

As we have seen in 5.2.2 above, capacity to give consent is a general requirement for legally valid
Any person who has the capacity to give consent can give legally valid consent to an intervention in regard of his or her own person. Spouses can consent independently to any type of medical intervention, even interventions affecting procreation, such as contraception, sterilisation or abortion, and even if they are married in community of property. This principle applies even where a spouse undergoes sterilisation purely for convenience sake, and in the absence of a medical indication (see discussion on sterilisation in 8.1.4).

Adults who are sober and sane are generally able to give consent. Youthful age and mental illness are two important factors excluding capacity to consent, but these are not the only factors. An unconscious person or someone in a state of delirium, shock or coma, or a person who is severely intoxicated or drugged, is most probably not in a position to give legally valid consent.

Tyger, who gets to hospital in an intoxicated state after fracturing a leg and sustaining lacerations as result of his bravado at his bachelor party (see 5.2.2.7), is clearly in no position to give consent to admission to hospital or surgery and sewing up of wounds. Elsie Geselsie, the admissions clerk at the hospital, now has the unpleasant task of looking for someone who can give consent on behalf of this sorry spectacle.

Fortunately the law makes provision for so-called substituted consent to medical interventions, in other words, consent by another person on behalf of the patient who is not able to give consent. The point of departure of section 7 of the National Health Act 61 of 2003 is that a health service may not be provided to a user without the user’s informed consent. However, section 7(1) of the Act provides as follows in respect of substituted consent:

(a) If a patient is unable to give consent, such consent can be given by someone who is

(i) mandated by the user in writing to grant consent on his or her behalf, or
(ii) authorised to give such consent in terms of any law or court order.

(b) If the patient is unable to give consent and no person is mandated or authorised to give such consent, such consent can be given by the patient’s

(1) spouse or partner (if any)
(2) parent
(3) grandparent
(4) adult child, or
(5) brother or sister

in the specific order as listed.

Note that where consent is given by someone else than the patient, that person, if possible, must first consult the patient (s 8(2)(a)). A patient who is able to understand must be informed about the matters referred to in section 6 of the Act (which we discussed in 5.3.3.2), even if he or she is unable
to give informed consent as required in section 7 (see s 8(2)(a)). Therefore, unless Tyger with the fractured leg and gaping wounds is so intoxicated that he is in a stupor, or cannot understand at all what is said to him, he has to be informed of the health services he is going to receive. For the purposes of section 7 informed consent is defined as consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6 (7(3)). If the patient is unable to participate in a decision affecting his or her personal health and treatment, he or she must be informed after the treatment of the relevant matters, unless the disclosure of such information would be contrary to the patient’s best interest (s 8(3)).

We have now discussed the general rules in respect of capacity to give consent, as well as the general rules in respect of substituted consent. We now discuss two types of persons governed by specific rules, namely minors and the mentally ill.

5.4.2 Minors

A child becomes a major upon reaching the age of 18 years (s 17 of the Children’s Act 38 of 2005). Can your minor child, brother or cousin independently give consent to an operation or medical treatment? One must remember that a minor normally requires the consent of a parent or guardian (Esterhuizen v Administrator, Transvaal 1957 (3) SA 710 (T)) because the minor is subject to parental authority. However, the situation is not so simple. The Children’s Act 38 of 2005 has somewhat complicated the position with regard to consent to medical interventions.

It is of course still the case that a minor who cannot independently give consent normally requires consent of a parent or guardian. It is to be noted that a parent may by common law delegate various incidents of his or her parental authority to a person who acts in loco parentis, such as a teacher, a youth leader or a relative who may be caring for the child temporarily. Where a parent has expressly or tacitly authorised such a person to consent to medical treatment on his or her behalf, that person may lawfully do so (see Boberg PQR The law of persons and family (1977) 316 n 9).

Can a minor independently consent to an operation or treatment? This question becomes of paramount importance where it is not a case of dire emergency and where the minor is not a neglected child or the inmate of an institution. Take the example of a scholar, university student, or office employee in his late teens who consults a doctor or a dentist. His parents live in a distant town or are on an overseas tour. His ailment is not such that there is an imminent threat to his life, but there is a clear indication in favour of medical treatment, which might involve surgery, without undue delay. The patient is obviously a responsible individual who can make an intelligent assessment of the situation after having been informed of the diagnosis. It would seem grossly unrealistic, if not unprofessional, for the doctor to defer treatment for several days or weeks until the parents can be reached and asked whether they consent to the treatment indicated.

The Children’s Act 38 of 2005 contains provisions which vest a child with certain decision-making
powers before reaching majority. It is important to note that some of these provisions stipulate both an objective age requirement and a subjective requirement in respect of maturity, while others require only an objective age requirement.

5.4.2.1 Medical treatment and surgery

Section 129 of the Children’s Act 38 of 2005 governs consent to medical treatment of and surgical operations on children. Section 129(2) stipulates that a child may consent to his or her own medical treatment or to the medical treatment of his or her child if the child is

(a) over the age of 12 years; and

(b) of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.

In terms of section 129(4) the parent, guardian or care-giver of a child may, consent to the medical treatment of the child if the child is

(a) under the age of 12 years; or

(b) over that age but is of insufficient maturity or is unable to understand the benefits, risks, social, and other implications of the treatment.

The provisions of subsection (4) are subject to the provisions of section 31, which stipulates that before a person holding parental responsibilities and rights in respect of a child takes any decision involving the child regarding (inter alia) the refusal or granting consent required by law in respect of that child, that person must give due consideration to any views and wishes expressed by the child, bearing in mind the child’s age, maturity and stage of development.

The Act defines care-giver as follows: any person other than a parent or guardian, who factually cares for a child including

- a foster parent
- a person who cares for a child with the implied or express consent of a parent or guardian of the child
- a person who cares for a child whilst the child is in temporary safe care
- the person at the head of a child and youth care centre where a child has been placed
- the person at the head of a shelter
- a child and youth care worker who cares for a child who is without appropriate family care in the community
- the child at the head of a child-headed household

Section 32(1) places an obligation on a person, including a care-giver, who has no parental responsibilities and rights in respect of a child but who voluntarily cares for the child either indefinitely, temporarily or partially, to, whilst the child is in that person’s care, safeguard the child’s health, wellbeing and development. Such person is also vested with the authority to consent to any medical examination or treatment of the child if such consent cannot reasonably be obtained from the parent or guardian of the child (s 32(2)).

Section 129(3) provides that a child may consent to the performance of a surgical operation on him or her or his or her child if the child is

(a) over the age of 12 years; and
(b) of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and
(c) duly assisted by his or her parent or guardian.

In terms of section 129(5) the parent or guardian of a child may consent to a surgical operation on the child if the child is
(a) under the age of 12 years; or
(b) over that age but is of insufficient maturity or is unable to understand the benefits, risks, social and other implications of the operation.

The provisions of subsection (4) apply, just as the provisions of subsection (5), subject to the provision of section 31. Any views and wishes expressed by the child, bearing in mind the child’s age, maturity and stage of development, must also be taken into account in this instance.

Note that a care-giver is not authorised by this section to consent to a surgical operation.

The legislator does not define “operation” or “treatment”. Each case thus has to be judged on merit. Should a dispute arise, the courts have to decide on the grounds of expert medical evidence what the difference between an operation and treatment is.

It is prescribed by regulation that consent to a surgical intervention on a child has to be given on a specific prescribed form. The person performing the operation or the representative of the facility where the operation is to be performed has to complete the form, and the child has to sign it (Reg 48 of the regulations promulgated and published in GG 33076 of 1 April 2010, R261). A parent or guardian who duly assists the child has to assent to this intervention in writing on the same form.

A problem may arise when a child who cannot independently give consent has to undergo an operation or medical treatment, but the parents or guardian refuse permission. However, section 129(7) of the Children’s Act 38 of 2005 offers a solution in such a case. The subsection provides that the Minister may consent to the medical treatment of or surgical operation on a child if the parent or guardian of the child
(a) unreasonably refuses to give consent or to assist the child in giving consent;
(b) is incapable of giving consent or of assisting the child in giving consent;
(c) cannot readily be traced; or
(d) is deceased.

The Minister may delegate his or her authority to certain officials or organs of state (s 307). Section 129(10) further expressly provides that no parent, guardian or care-giver of a child may refuse to assist a child in terms of subsection (3) or withhold consent in terms of subsections (4) or (5) by reason only of religious or other beliefs, unless that parent or guardian can show that there is a medically accepted alternative choice to the medical treatment or surgical operation concerned.

You are visiting friends with young children. A friend of one of the children, known to you only as “Maya”, sleeps over. A swarm of bees attacks her and she is stung quite badly. She is allergic to bee venom. Her throat swells up and she struggles to breathe. You rush her to hospital in your car. Antihistamines, adrenaline and
Corticosteroids do not help and she has to have a tracheotomy to help her breathe. You don’t know any of her relatives, and treatment cannot be postponed. Who has to be approached for consent?

The Children’s Act 38 of 2005 provides (s 129(6)) that the superintendent of a hospital or the person in charge of the hospital in the absence of the superintendent may consent to the medical treatment of or a surgical operation on a child if

(a) the treatment or operation is necessary to preserve the life of the child or to save the child from serious or lasting physical injury or disability; and

(b) the need for the treatment or operation is so urgent that it cannot be deferred for the purpose of obtaining consent that would otherwise have been required.

There may be cases of absolute emergency where it would be totally impractical or dangerous to postpone an intervention in order to first get permission from the superintendent or the Minister’s delegate. An example is heart failure which necessitates immediate heart-lung resuscitation. A doctor, nurse or paramedic can certainly intervene immediately without first getting consent or official authorisation. We submit that the saviour may in such a case rely on negotiurum gestio, the common-law ground of justification.
May a child refuse medical treatment or a surgical operation? Section 129(1) of the Act provides that a child may only be subjected to medical treatment or a surgical operation if consent has been given in terms of subsections (2), (3), (4), (5), (6) or (7) (which we discussed above). As we have seen, subsections (2) and (3) authorise a child complying with both the age and the maturity requirement to consent to such interventions. It would thus seem as if a child who complies with the age and maturity requirements may refuse to undergo medical treatment. However, what is very clear is that a child who unreasonably refuses to undergo such intervention may be subjected thereto without his or her consent. This is evident from section 129(8) which authorises the Minister to consent to medical treatment or an operation if a child unreasonably refuses to give consent.

A child who does not comply with both the age and maturity requirements may apparently not refuse to undergo such interventions.

Section 129(9) provides that a High Court or children’s court may consent to the medical treatment of or a surgical operation on a child in all instances where another person that may give consent in terms of this section refuses or is unable to give such consent.

The statutory provisions discussed do not detract from the rule that the High Court is the upper guardian of minors and has the last say also with regard to medical interventions performed on minors. The High Court may be approached to authorise a medical intervention, particularly where there is a dispute between parent and child, or between parent and doctor, or where there is an unreasonable parental refusal to consent to a medical intervention. The Court will be guided by the minor’s best interest. See Hay v B 2003 (3) SA 492 (W), where a blood transfusion on an infant with a serious condition had to be administered within three to four hours in order to save the child’s life. The parents objected on religious grounds and because of their fear that the blood might be infected. The doctor involved approached the court for an urgent order allowing her to administer blood to the baby. Relying on section 28(2) of the Constitution the court ruled that a child’s best interests are of paramount importance in every matter concerning the child. Moreover, the right to life is a value that is constitutionally protected, and the baby’s right to life may not be violated. Even though the parents’ religious beliefs have to be respected and their concern was understandable, it is not reasonable and justifiable, and could not be more important than the baby’s right to life. The baby’s right to undergo a blood transfusion is more important than the reasons the parents advanced to oppose it.

In the case of minor prisoners the provisions of section 12(4)(c) of the Correctional Services Act 111 of 1998 apply. It provides that surgery may not be performed on a minor prisoner without the written consent of his or her legal guardian (s 12(4)(c). Consent to surgery is not required, however, if, in the opinion of the medical practitioner who is treating the minor prisoner, the intervention is in the interests of the prisoner’s health and it is not possible or practical to delay it in order to obtain the consent of his legal guardian (s 12(4)(d)).

5.4.2.2 HIV tests

The Children’s Act 38 of 2005 regulates consent to HIV separately in section 130. A child under the age or 12 years may give consent to an HIV test if he or she is of sufficient maturity to understand the benefits, risks and social implications of such a test (s 130(2)(a)(ii)). If the child is not of sufficient maturity to understand the benefits, risks and social implications of such a test, consent may be given by

- the parent or care-giver (s 130(2)(b))
the provincial head of social development (s 130(2)(c))

- a designated child-protection organisation arranging the placement of the child (s 130(2)(d))

The superintendent or person in charge of a hospital may also give consent if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test, on condition that the child has no parent or care-giver and there is no designated child protection organisation arranging the placement of the child (s 130(2)(e)).

A children’s court may give consent if consent is unreasonably withheld in terms of paragraphs (a), (b), (c) or (d), or the child, parent or caregiver is incapable of giving (s 130(2)(f)).

The Children’s Act 38 of 2005 provides in section 130(2)(a) that a child over the age of 12 years may give consent to an HIV test. A children’s court may however still give consent if the child unreasonably withholds consent, or is incapable of giving consent (s 130(2)(f)).

5.4.2.3 Contraceptives

Justin Puber, a Grade 7 learner, walks into a pharmacy and nonchalantly places a packet of condoms on the counter. The pharmacist looks upset, and does not feel comfortable selling contraceptives to such a young “teeny bopper”. Do you think the pharmacist may refuse to let Justin buy the condoms?

By law no-one may refuse to sell condoms to a child over the age of 12 years, or to provide a child over the age of 12 years with condoms on request where such condoms are provided or distributed free of charge (s 134(1)).

Justin Puber’s 12 year old girlfriend, Vinnie, visits a doctor without her parents’ knowledge in order to get a prescription for oral contraceptives. Is the doctor obliged to give her the prescription?

Contraceptives other than condoms may (NB: not must) be provided to a child on request by the child and without the consent of the parent or care-giver of the child if the child is at least 12 years of age, proper medical advice is given to the child, and a medical examination is carried out on the child to determine whether there are any medical reasons why a specific contraceptive should not be provided to the child (s 134(2)).

Whatever the two young ones in our scenarios are planning, they had better read what the Criminal Law Sexual Offences and Related Matters 32 of 2007 and in particular sections 15 and 16 provide. We may just mention in passing that sexual penetration of a child, as well as an act that causes direct or indirect contact between the genital organs of the child and any part of the body of another person, constitutes an offence, even if the child agreed to this act. These provisions apply to children between the ages of 12 and 16.
5.4.2.4 Abortion
In terms of the Choice on Termination of Pregnancy Act 92 of 1996 a girl who is a minor may independently consent to an abortion. No age restriction is set. However, the Act provides that abortion may only be performed with the informed consent of the pregnant woman. Remember that informed consent may only be given by a person with the necessary intellectual and emotional capacity. The girl must therefore be intellectually and emotionally mature enough to understand the nature and consequences of the intervention. (See in this regard Christian Lawyers' Association v National Minister of Health [2004] 4 All SA 31 (T) 37–38.)

In G v Superintendent, Groote Schuur 1993 (2) SA 255 (C) the court refused a mother’s application that an abortion that were to be legally performed on her 14 year old daughter who had been raped, not take place.

It is doubtful whether a court would be willing to order that a legal abortion be performed against the wishes of a girl capable of independent consent, on request of her parents. (Our courts have already refused to order that an illegal abortion be performed against the will of a pregnant girl – see Strauss 212.)

5.4.2.5 Sterilisation
As a rule only a person of 18 years or older and capable of consenting may be sterilised (s 2(1) of the Sterilisation Act 44 of 1998). However, provision is made for sterilisation of a person younger than 18 years of age in certain narrowly defined circumstances. This is discussed later in 8.1.2.

5.4.2.6 Virginity tests
Virginity tests on a child younger than 16 years of age are prohibited by section 12(4) of the Children’s Act 38 of 2005. They may only be performed on a child over 16 years of age if the child has given written consent on the prescribed form. See section 12(5) of the Act and Regulation 3 of the regulations promulgated and published in GG 33076 of 1 April 2010, R261.

5.4.2.7 Circumcision
Circumcision of a male person may be performed for medical purposes. Circumcision of males and females is an important cultural custom in certain societies. Ritual circumcision of young males is performed in a number of ethnic groups in Africa as part of the so-called initiation ceremony. It indicates the rite of passage from boy to man. Circumcision of boys is required by several religions, and is for example very common amongst adherents of the Muslim and Jewish faith.

Circumcision of male children under the age of 16 is prohibited (s 12(8)) of the Children’s Act 38 of 2005), except when
(a) circumcision is performed for religious purposes in accordance with the practices of the religion concerned and in the manner prescribed; or
(b) circumcision is performed for medical reasons on the recommendation of a medical practitioner.

If it is performed for religious purposes both parents have to give consent (Reg 6 of the regulations promulgated and published in GG33076 of 1 April 2010, R261). If more than one person has
guardianship over the child, or where there is a parental responsibilities and rights agreement, both such persons have to give consent. A form is prescribed by regulation for this purpose.

Circumcision for religious reasons of male children older than 16 may only be performed in the prescribed manner and after the child has given consent on the prescribed form (s 12(9) and Reg 6).

Circumcision for social or cultural reasons (such as initiation) of a male child older than 16 may only be performed in the prescribed manner and after the child has given consent on the prescribed form (s 12(9) and Reg 5).

Circumcision of female children (as well as genital mutilation) is prohibited (s 12(3)).

5.4.2.8 Medical examination of victims of sexual or violent offences

Here we must mention section 335B of the Criminal Procedure Act 51 of 1977. This section governs medical examination upon the initiative of a police official of a minor who has been the victim of a sexual offence or an offence of a violent nature, where the parent or guardian

(a) cannot be traced within a reasonable time
(b) cannot grant consent in time
(c) is a suspect in respect of the offence in consequence of which the examination must be conducted
(d) unreasonably refuses to consent that the examination be conducted
(e) is incompetent on account of mental disorder to consent that the examination be conducted
(f) is deceased.

A magistrate must then be approached for consent. If a magistrate is not available, certain senior police officers may give consent, subject to certain procedural requirements.

Apart from the common-law principles and statutory provisions which we discussed above, the provisions of the National Health Act 61 of 2003 in respect of substituted consent (see 5.4.1) may also apply in some cases concerning medical treatment of minors.

5.4.3 The mentally ill

5.4.3.1 General

At the outset it should be pointed out that the mere fact that a person is mentally ill does not necessarily mean that such a person is unable to consent to medical treatment (including psychiatric treatment) or an operation. Mental illness can manifest itself in a variety of conditions and its severity could range from mild to extremely severe. What is more, even a person with a serious form of mental illness, such as schizophrenia, could experience lucid intervals (lucida intervalla). Where a patient is known to be mentally ill, it will therefore be necessary for a doctor first to establish whether the patient is capable to give consent. In certain circumstances it may be necessary to seek assistance from a psychiatrist in order to establish the patient’s competency to give consent.

In the case of a minor patient who is unable to consent on account of mental illness, a parent or guardian may give the necessary consent. This situation is now governed by section 129 of the Children’s Act 38 of 2005. As far as a major patient who is incapable of consenting is concerned, the
personal curator could, by common law, consent. This was confirmed in *Ex parte Dixie* 1950 (4) SA 748 (W).

In this case the doctors had recommended a leucotomy (a type of brain operation that can result in behaviour modification). The court ruled, in general terms, that a non-emergency operation cannot lawfully be performed without the consent of the patient. If he is not competent to give it, consent must be given by “some person in authority over his person”. The judge declared: “The fact that he is a patient in a hospital does not entitle those in charge of it to perform any surgical operation upon him which they may consider beneficial.” A curator for the person of the patient was accordingly appointed by the court to consider whether an operation was to be performed and to consent thereto if it was so decided.

From *Dixie* it is apparent that in the case of a serious non-emergency operation, a parent or relative of a mental patient is not legally entitled simply to give the necessary consent. Even if a relative were legally entitled to give consent, the sad fact is that mental patients, detained in institutions, are sometimes abandoned by their relatives. The appointment of a personal curator, again, would involve a costly application to the High Court.

What about the patient who is in private care and has neither a curator nor relatives, or who has been deserted by his relatives? The regulations to the Mental Health Care Act 17 of 2002 stipulate that the head of the health care institution or licenced private facility where the mental health service is provided has to give consent for treatment or an operation where none of the persons who may consent on behalf of the health care user, can be traced. See further discussion on this topic in 5.4.3.3 below.

In cases of dire emergency where a life-saving operation must be performed without delay, hospital doctors may do so without going through the process of having a personal curator appointed by the High Court, or without even seeking the approval of some person in authority over the patient’s person (see *Dixie* at 751 C–D).

Note that as far as abortion is concerned special provision has been made in respect of mentally disabled women in the Choice on Termination of Pregnancy Act 92 of 1996. We discuss the provisions in 8.2.9 below.

Note further that there are also special provisions pertaining to the sterilisation of mentally incompetent minors, which we discuss in 8.1.3 below.

The provisions of the National Health Act 61 of 2003 on substituted consent, which we discussed above in section 5.4.1, may be relied upon in some situations involving non-emergency medical treatment of mentally ill persons, but do not cover the type of situations where no spouse or relatives can be traced.

5.4.3.2 The Mental Health Care Act 17 of 2002

The Mental Health Care Act 17 of 2002 which took effect on 15 December 2004 contains a number of sections relating to aspects of consent to the treatment of a mentally ill person. This Act repealed the Mental Health Act 18 of 1973 (except for chapter 8 governing hospital boards.)

The Mental Health Care Act differentiates between “voluntary”, “assisted” and “involuntary” care, treatment and rehabilitation (hereinafter referred to as “interventions”) (see s 1).
Voluntary care, treatment and rehabilitation means the provision of health interventions to a person who gives consent to such interventions.

Assisted care, treatment and rehabilitation means the provision of health interventions to people incapable of making informed decisions due to their mental health status and who do not refuse the health interventions.

Involuntary care, treatment and rehabilitation means the provision of health interventions to people incapable of making informed decisions due to their mental health status and who refuse health intervention but require such services for their own protection or for the protection of others.

Section 9(1) provides that a health care provider or a health establishment may provide care, treatment and rehabilitation services to, or admit a mental health care user, only if

(a) the user has consented to such interventions or admission;
(b) such interventions or admission is authorised by a court order (as in *Ex parte Dixie*) or a Review Board; or
(c) due to mental illness, any delay in providing such interventions or admission may result in the
   (i) death or irreversible harm to the health of the user;
   (ii) user inflicting serious harm to himself or herself or others; or
   (iii) user causing serious damage to or loss of property belonging to him or her or others.

Section 9(1)(c) thus makes provision for intervention in an emergency, that is, where treatment is urgently needed, and for reasons set out in paragraphs (i) to (iii) of subsection 1(c) may not be postponed.

The Act contains detailed provisions in respect of the administrative process to be followed when an application is brought for assisted and involuntary care. Of importance with reference to the latter category is the 72 hour assessment period as set out in the Mental Health Care Act 17 of 2002 which has to expire after an application for involuntary care was approved by the head of the healthcare establishment. At the end of such period a final decision is taken on the necessity of continued involuntary care.

The Act also makes provision for appeal against the decision of the head of the health care establishment. Such appeal is heard by the Review Board.

The Act also ensures periodic review of the mental state of the mental health care user. It would seem as if mental health care users may remain in psychiatric hospitals or other facilities providing the required service for an indefinite period of time.

A Review Board must be established for every health establishment providing mental health care, treatment and rehabilitation services in that province (s 18). Review Boards bear responsibility, *inter alia*, for making decisions regarding assisted or involuntary interventions.

5.4.3.3 Consent to treatment or operations for an illness other than a mental illness

The provisions of the Mental Health Care Act 17 of 2002 in respect of consent, which we discussed above, apparently only applies in the realm of care, treatment or rehabilitation services that a mental health care user receives, or a health care service which such person uses, from a health care
establishment aimed at improving the mental health status of the user. It seems as if these provisions thus only apply in respect of consent to interventions aimed at improving the person’s mental health care status. This conclusion is strengthened by the provisions of Regulation 35, promulgated and published in GG 27117 of 15 December 2004, R1467, as amended by R 89 of 11 February 2005, GG 27236.

Regulation 35 provides for consent to interventions in respect of an illness other than a mental illness. In terms of the regulation an involuntary mental health care user, an assisted mental health care user, a state patient or a mentally ill prisoner who is capable of giving informed consent to treatment or an operation, must decide whether to have treatment or an operation or not (Subreg (1)).

Where a mental health care practitioner deems a user to be incapable of consenting to treatment or an operation due to mental illness or intellectual disability, then a curator, if a court has appointed one, a spouse, next of kin, a parent or guardian, a child over the age of 18, a brother or sister, or a partner or associate, may consent to the treatment or operation (Subreg (2)).

Subregulation 3 provides that the head of the health establishment or the head of a licensed private facility where the mental health care user resides, may grant consent to treatment or an operation if

(a) none of the persons contemplated in Sub-regulation (2) is available and unsuccessful attempts have been made to locate them and this has been confirmed in writing;
(b) the relevant alternatives have been discussed with the head of the health establishment or facility concerned and that head is satisfied that the most appropriate intervention is to be performed; and
(c) the medical practitioner who is going to perform that operation recommends the treatment or operation.

5.5 Interventions without the patient’s consent

We have discussed above consent as the most important ground of justification for medical interventions. However, the mere fact that an intervention has been performed without informed consent does not necessarily mean that the intervention was unlawful/wrongful. If another ground of justification is present, the intervention will be lawful.

The National Health Act 63 of 2003, section 7 also makes provision for treatment without consent. Section 7 provides that a health service may be provided to a user without his or her informed consent where

- the provision of the health service without informed consent is authorised in terms of any law (s 7(1)(c))
- the provision of the health service without informed consent is authorised in terms of a court order (s 7(1)(c))
- failure to treat the user (or a group of persons including the user) might result in a serious risk to public health (s 7(1)(d)) – note that no requirement in respect of emergency is set here
- any delay in the provision of the health service to the
...user might result in his or her death or irreversible damage to his or her health, and the
user has not expressly, impliedly or by conduct refused that service (s 7(1)(e)).

The provisions in section 8 (which we discussed in 5.4.1 above) obliging medical personnel to
inform the non-consenting patient after treatment also apply here.

In section 9 the National Health Act makes provision for hospitalisation of a patient without consent. 
When such an admission takes place, the hospital or other health care establishment must inform
the head of the provincial health care department within 48 hours, unless the 48 hours expire on a 
Saturday, Sunday or public holiday, in which case a more lenient arrangement applies. However,
this obligation does not apply if the patient gives consent within 24 hours.

The provisions of section 7 of the National Health Act 61 of 2003 set out above are essentially in line
with the common-law position. The common law also recognises statutory authority and court order
as general grounds of justification, and it also recognises that medical interventions may be lawfully
performed in circumstances where the requirements of necessity or negotiorum gestio are met. As
the provisions of section 7 as such bestow statutory authority for the provision of health care
services in circumstances set out therein, statutory authority will overlap in the required
circumstances with the other common-law grounds of justification.

5.5.1 Statutory authority

Where legislation authorises medical intervention without consent, such intervention is lawful. 
Examples of such statutory provisions include the following:

- section 7(1)(d) of the National Health Act 61 of 2003 authorising provision of a health service
  where failure to treat the patient (or a group of persons which includes the patient) poses a
  serious threat for public health (even where no emergency exists)
- section 37(2) of the Criminal Procedure Act 51 of 1977 authorising taking a blood sample which
  may be relevant in criminal proceedings
- Regulations 14 and 17 promulgated and published in GN R2438, GG 11014 of 30 October 1987
  authorising the compulsory examination, hospitalisation and treatment of persons suspected of
  carrying a communicable disease
- Regulation 13 promulgated and published in GN R2438, GG 11014 of 30 October 1987
  authorising compulsory immunisation in certain circumstances

Note that statutory authority may also overlap with other grounds of justification. For example,
statutory authority will overlap with negotiorum gestio where a doctor in an emergency or when a
dentist is not available, performs acts pertaining to the dental profession (see 3.7.4).

5.5.2 Court order

A court order may justify treatment without a patient's consent as long as it is not against the
patient's will. We have already pointed out that the High Court as upper guardian of minors also has
the last say in respect of medical interventions on minors (see 5.4.2.1).

However, it is a moot question whether a court may order that a patient be subjected to a medical
intervention against his or her will. In view of the importance of patient autonomy in our law we

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submit that a court will only in exceptional circumstances and in the public interest (eg to protect another’s interests) make such an order. In *Minister of Health, Western Cape v Goliath* 2009 (2) SA 248 (C) the Minister of Health of the Western Cape brought an application for an order that the respondents, who had been diagnosed with highly infectious and extensive drug resistant tuberculosis (XDR-TB) be admitted to a facility and detained there until they were cured. The application was brought (in terms of s 38 of the Constitution) in the public interest and in the interest of people who may be exposed to XDR-TB and be infected. The respondents, who were unwilling to voluntarily be isolated, contended that isolation in such facility would violate their right to freedom as entrenched in section 12 of the Constitution, 1996. However, the court found that isolation of patients with communicable disease is universally acknowledged in open and democratic societies as justified to protect the health of the citizens, and granted the application. The respondents argued that the provisions of section 7 of the National Health Act 61 of 2003 are not applicable as their detention did not amount to “provision of a health service without informed consent” (s 7(1)(c)) but detention of persons against their will. The court rejected their argument and held that the concept of “health service” is wide enough to encompass involuntary isolation of patients with communicable diseases in a health establishment funded by the state.

5.5.3 Medical interventions without consent in cases of emergency

We have already met Maya, the child with the bee-sting allergy and breathing problems (5.4.2.1 above). You get to the hospital with the child, but there is no time to wait for consent from the superintendent to save the poor soul. Enter Dr Hector Powerball, surgeon of fame! He quickly assesses the situation and in a flash produces his favourite scalpel which he always has at hand for situations such as these. Soon the child is sleeping peacefully in the high care unit with a breathing pipe in her throat, and you heave a sigh of relief. Phew! But wait, soon Dr Powerball will have to explain to Maya’s parents why he took such drastic action without any consent.

We have to mention at the outset that a doctor cannot be held liable if he or she acted reasonably in an emergency, but the measures prove to be of no avail and the patient dies. See *S v Kramer* 1987 (1) SA 887 (W). In this case a catastrophe occurred when an anaesthetist failed to insert an endotracheal tube (a tube supplying oxygen) correctly and the surgeon in vain applied desperate measures to try and save the patient’s life.

In our common law there are two grounds of justification for emergency situations, namely necessity and *negotiorum gestio* (spontaneous agency/unauthorised administration). (Legislation may of course also authorise administering emergency medical treatment in particular circumstances.) Determining the legal ground on which the emergency intervention is based is not important from a theoretical point of view only, but also on practical grounds, namely to determine the extent to which the doctor may justifiably intervene. It also has private-law implications, namely for determining the extent to which the doctor is entitled to compensation for services rendered in the emergency situation.

At this stage we have to mention that the essence of necessity as ground of justification for medical interventions is a combination of the existence of an emergency and violation of a patient’s physical
integrity against his or her will. On the other hand the essence of *negotiorum gestio* as *ground of justification* for medical interventions is a combination of the existence of an emergency and the impossibility to obtain the patient’s consent.

### 5.5.3.1 Necessity

In current South African law *necessity* (“inevitable evil”) is in fact regarded as a general *ground of justification*. *Necessity* is a *ground of justification* for an act performed by a person to protect that person’s own or another’s legally recognised interest, or the public interest, against an already present or immediately threatening danger which cannot be warded off in any other way. However, the person must not be legally obliged to endure said danger, and the interest that is protected by the protective act must not be disproportionate to the interest violated by the act.

Dr Rose Thornton is visited by a frail girl, Maleficient, complaining of severe backache. Dr Thornton injects an anti-inflammatory drug to relieve the pain. On disposing of the needle the doctor accidentally pricks her own finger. She worries that the patient may be HIV positive and that she might have infected herself through the pricking of her finger. Maleficient refuses to have a blood test done to establish her HIV status. A counsellor, sister Merryweather, is called in to explain to Maleficient that the doctor has to establish whether Maleficient is HIV positive so that the doctor may take medicine to protect herself against infection. Maleficient still refuses. Sister Merryweather takes Maleficient’s hand in her own and explains that the medicines have nasty side-effects and that the doctor will probably have a very bad reaction to the drugs. It will also be fruitless to test the doctor for HIV as such tests may be negative for quite a while, even though she may indeed be infected. “That’s her problem, not mine,” Maleficient replies. The doctor and Merryweather look at one another and nod. Merryweather grips the girl’s hand more tightly and presses her arm to the table. Dr Thornton is ready with a syringe, and takes a blood sample to be sent for testing. Afterwards Merryweather explains to Maleficient that this test will be done at the doctor’s expense and that Maleficient will not be informed of the result, unless she wants to be informed, in which case she should phone the doctor. Do you think Dr Thornton’s action can be justified?

A characteristic of a typical emergency situation is that the **interests of an innocent third party are sacrificed to protect the interests of the person threatened**. See Snyman CR *Criminal law* 5 ed (2008) 115–121; Burchell J *Principles of criminal law* 3 ed (2005) 257. (But also see Neethling et al 82 fn 339.) This pattern is absent in most cases of medical treatment. The person threatened (the patient) is generally also the person in respect of whom the “protective act” occurs.

It is not a requirement for *necessity* as a *ground of justification* that the patient was incapable of consenting, or that the emergency intervention must be intended to serve the patient’s best interests. Since *necessity* basically entails the objective weighing up of interests, and since even an innocent third party’s interests may be sacrificed under *necessity*, it is clear that the person acting in *necessity* need not honour the patient’s wishes in so doing.

Necessity will be the *ground of justification* where the medical treatment of a person is administered
directly in the interests of society at large. This occurs when the medical treatment is necessary to prevent a dangerous disease from which the patient is suffering from spreading to others, or to prevent healthy people from contracting a disease which has reared its head in the community. Necessity consequently justifies the treatment of persons suffering from a dangerous infectious disease and the vaccination of healthy persons in order to prevent the spread or outbreak of a dangerous epidemic. In these cases the consent of the person against whom the action is taken is irrelevant, and treatment may even be administered against his or her will.

Such action will clearly be justifiable in extreme circumstances only, and ordinarily will be the subject of express statutory regulation. Here, the intervention may also be justified by statutory authority. Thus provision for compulsory medical examination and treatment of suspected carriers of AIDS and other serious communicable diseases was made (GN R2438 GG 11014 of 30 Oct 1987, promulgated in terms of the Health Act 63 of 1977 referred to in 5.5.1 above). (The constitutionality of these provisions is, however, open to serious doubt.) The National Health Act 61 of 2003 (s 7(1)(d)) provides for an exception to the general rule that a health service may not be provided to a user without his or her informed consent where failure to treat the user, or group of people which includes the user, will result in a serious risk to public health.

5.5.3.2 Negotiorum gestio (spontaneous agency or unauthorised administration)

(a) Introduction

Negotiorum gestio is the ground of justification in our common law which is best suited to a situation related exclusively to the interests of a patient and not to the interests of society. Negotiorum gestio in its common-law origin is ordinarily concerned with the protection by one person of the patrimonial interest of another in the absence of the latter person. However, there is no reason why this doctrine should not be extended to a situation where the party who is “threatened” is in fact physically present but psychologically “absent” due to unconsciousness. In any event, absence from the place where the gestor acts is not a requirement for negotiorum gestio. The only requirement is that he or she should be unaware of the protection of his or her interests by the gestor. A person who is unconscious can no more protect his own interests than a man who is a thousand kilometres away.

Furthermore there is no reason why negotiorum gestio cannot also include the protection of the interests of personality. Our common-law authors have acknowledged negotiorum gestio also where a person provided maintenance for the children of another. The support of children, after all, is not concerned primarily with the protection of a patrimonial interest of the father. In any event, an act aimed directly at protecting a personality interest often indirectly promotes the protection of a patrimonial interest. If a doctor operates timeously on an unconscious patient, she may by her action avert grave complications which might later cause the patient medical expenses amounting to thousands of rand and which might result in occupational disability (and the resultant lack of income).

(b) Requirements

The relevant requirements for negotiorum gestio may be briefly summarised as follows:

(i) A situation of emergency must exist.

Intervention must be necessitated by a threat to the patient’s life or health. The emergency must be of such a nature that intervention cannot be delayed until the patient will be in a position to consent.
(ii) The *dominus* must be incapable of consenting.

Since the general rule is that a patient must consent to an intervention, *negotiorum gestio* is out of the question unless the patient is incapable of consenting. An imminent threat to the patient’s health or life is not sufficient reason for intervention, since the patient’s right to autonomous decisionmaking is so highly regarded in our law that a patient may refuse treatment that is clearly medically indicated. In fact, a patient may even refuse treatment that may save his or her life. Therefore, if the patient is capable of consenting, the applicable ground of justification is consent, and the health care provider must ensure that the patient’s consent is procured. Permanent incapacity is not required for *negotiorum gestio*, however. It is sufficient if the patient’s situation is such that intervention would be needed before such time as he or she might gain or regain the capacity to consent. The patient may, for instance, be temporarily comatose, or unconscious as a result of an overdose of drugs or alcohol. The incapacity to consent may also be the result of delirium or severe shock.

(iii) The intervention must not be against the patient’s (*dominus’*) will.

Since *negotiorum gestio* is premised on the idea that the *dominus* probably would have consented if he or she had been in a position to do so, the *gestor* may not act against the *dominus*’ will or direction. In the health care context, this means that the health care provider can rely on the defence only if the patient had not previously, whilst capable of consent, given an indication of being opposed to the (type of) intervention concerned. Say for instance, on account of his religious convictions, the *dominus* patient is opposed to blood transfusions. The patient is involved in a vehicle accident, loses a lot of blood, and needs a blood transfusion to survive. *Negotiorum gestio* will not avail the doctor of a ground of justification if she administers a blood transfusion to save the patient’s life. The doctor’s action will be unlawful/wrongful, unless justified by another ground of justification. However, if the doctor was ignorant of the patient’s convictions/prohibition, she may escape liability based on absence of awareness of unlawfulness/wrongfulness. Awareness of unlawfulness/wrongfulness is generally required for intention to be present.

(iv) The *gestor* must act with the object of serving the interests of the *dominus*.

This means that the intervention must be intended to save the patient’s life or safeguard his or her health.

(c) *Gestor must complete what he or she has begun*

A doctor or other health care provider who comes to the rescue of a patient may not simply abandon his or her self-imposed task of rescuing a patient once he or she has taken charge of the situation. The *gestor* must complete what he or she has commenced to do, and must do so with reasonable care and skill. (Compare 5.6.2.1 and 5.6.2.2 below.)

(d) *Gestor has right to remuneration*

A doctor or other health care provider who, in rendering emergency medical services to a patient, acted in accordance with the requirements for a valid defence of *negotiorum gestio*, is entitled to be remunerated by the patient for any loss suffered or expenses incurred as a result of the rescue action, provided that the *gestor*’s rescue action was performed with the intent to claim remuneration.

(e) *Gestor has a right to recover damages*

A doctor or health care provider may conceivably also sustain injury or suffer other harm in the course or as a result of the rescue action. The *gestor* has a right to recover damages for such injury
or harm from any person responsible for causing the emergency in a negligent or intentional manner. The author of the emergency situation through his or her conduct imperiled not only the patient but also the patient’s rescuer. The person responsible for the emergency cannot rely on the defence of voluntary assumption of risk if the gestor acted in execution of a legal or ethical duty. If contributory negligence on the gestor’s part can be established, the normal rules relating to the apportionment of damages will apply.

5.6 Duty to act

We have said above that a medical intervention is generally justified by consent, and that such a viewpoint is in line with the high value placed on autonomy or self-determination by our law. We have also seen that consent is not always a ground of justification for an intervention. For example, statutory authority, a court order, necessity or private defence may also justify an intervention in the relevant circumstances. This leads us to the next question: We now know under which circumstances doctors may act, but are they also obliged to act? In other words, must they in the relevant circumstances act positively? Can they be held liable if they desist from acting?

5.6.1 General criterion: the boni mores

In terms of the ethics of the medical profession there is an obligation on a doctor to assist in an emergency situation (ie where no doctor-patient relationship exists). The ethical guidelines of the HPCSA stipulate that doctors must provide health care in emergency situations within the parameters of their practice, experience and competence. If they are unable to provide this help they must refer the patient to a colleague or facility where he or she may be cared for. However, the guidelines provide that, in an emergency, doctors are obliged first to render assistance to stabilise the patient, whereafter they may make a suitable referral. If a doctor-patient-relationship has already been created, the ethical rules of the HPCSA stipulate that the doctor has at all times to act in the patient’s best interests. The guidelines also stipulate that within the normal limitations of their practice doctors have to be accessible to their patients when they are on duty, or make arrangements for accessibility when they are not on duty (see 4.1.1.2).

Whatever the moral or ethical consequences may be for a physician who refuses to give medical help to a sick or injured person, it may be stated that generally he or she would not incur criminal or delictual liability merely by virtue of such refusal. For example, take the physician who arrives by chance at the scene of an accident. His help could save the injured person from death and from serious, perhaps permanent, harm to health. Suppose that the physician neglects to provide medical help?

Today it is accepted that a mere omissio can in fact lead to delictual as well as criminal liability where the circumstances are such that the person concerned could reasonably be expected to intervene. In Minister van Polisie v Ewels 1975 (3) SA 590 (A) 597A the Appeal Court stated as follows:

It appears that the stage of development has been reached where an omission may be regarded as unlawful conduct also where the circumstances are of such a nature that the omission would not only evoke moral indignation, but also that the legal convictions of the community would require that the omission ought to be regarded as unlawful and that the
damage suffered ought to be made good by the person who failed to act positively. (Our translation.)

The standard is thus that of the legal convictions of society, or the *boni mores* (see Neethling J, Potgieter JM & Visser PJ *Law of delict* 5 ed (2006) 33–34; 49–70).

A court might conceivably find that a physician’s failure to act in any particular situation makes him criminally liable because the *boni mores* demand that he ought to have acted in the particular circumstances. In judging whether the doctor’s omission was contra bonos mores, all relevant circumstances have to be considered, including the following:

- the doctor’s knowledge of the patient’s condition
- the gravity of the condition
- the doctor’s professional competence and skill
- the availability of other doctors or healthcare providers such as paramedics
- the interests of other patients
- possible danger to the doctor through treating the patient
- the patient’s wishes in respect of the treatment
- professional ethical considerations

However, we submit that a court should only reach such conclusion after serious consideration.

### 5.6.2 Specific circumstances resulting in a duty to act

Apart from the duty to act, which is now recognised by virtue of the *boni mores*, there are certain situations which have been accepted in older case law as situations in which a duty arose to act positively. These situations are crystallised forms of the legal convictions of the community. They reflect the legal convictions of the community as interpreted by the courts. We will now consider them.

#### 5.6.2.1 Commissio per omissi\*onem

Where the perpetrator, by a positive action, creates a potentially dangerous situation, a duty arises to take precautions to avert the danger (the so-called *commissio per omissi\*onem*).

Applied to our present discussion this would mean that where a physician came upon an unconscious person suffering from an injury or from disease, and gave him treatment which necessitated medical precautions, but then culpably neglected to take such precautions so that the patient died in consequence of this, the physician might be criminally liable.

Some of the situations in point might also possibly be classified under the doctrine of *negotiorum gestio*. We discussed this doctrine in 5.5.3.2. It is a principle of *negotiorum gestio* that the *gestor* is under an obligation to complete what he began. Once he has undertaken to further the interests of another, he cannot merely abandon his undertaking.
5.6.2.2 Accepting control of a dangerous object

Where a person accepts control of a dangerous object a duty arises to exercise proper control over it.

The classic example is derived from Roman law. A makes a fire and B undertakes to keep an eye on the fire. B neglects this, the fire spreads, and a house is razed. B is liable for the damage (D 9.2.27.9).

A, a doctor, is busy with a blood transfusion on C. A is urgently called elsewhere and asks his colleague, B, who by chance is available, to take over the transfusion. B fails to take proper control over the instrument or process and C dies. B may be criminally liable.

An interesting example from psychiatry is Seema v Executive Member, Gauteng 2002 (1) SA 771 (T). Here a gravely disturbed person was admitted to a hospital where the defendant was in charge. The patient was moved from a security ward to an ordinary ward. There was no security fence around the hospital, and moreover no particular attempt was made to guard the hospital premises. The patient, who was dangerous, escaped from the hospital, kidnapped the defendant’s daughter, and raped her. The court awarded damages to the plaintiff. The court found that there was a legal duty on the defendant to protect the broader public against unlawful conduct by some patients in the facility. The defendant’s failure to take proper precautions in order to prevent patients leaving the premises rendered him liable for damages.

In S v Kramer 1987 (1) SA 887 (W) an anaesthetist failed to monitor his patient constantly and to ensure that the endotracheal tube remained correctly inserted. The patient subsequently died and the anaesthetist was convicted of culpable homicide.

In Magware v Minister of Health NO 1981 (4) SA 472 (Z) the casualty medical staff of the hospital incorrectly applied a plaster of Paris cast. Thereafter they were guilty of the following negligent omissions: after they had applied the plaster of Paris cast they failed to check the fracture dislocation by means of X-rays as they should have done, but did so only later on. Despite the fact that the X-ray taken later revealed that the fracture was in an unacceptable position and required immediate correction, they failed to take the appropriate action to correct it. The court held that once the defendant’s employees had undertaken treatment and had engaged in applying the plaster of Paris cast, a special relationship arose between the defendant’s employees (the casualty medical staff) and the plaintiff, which differed from the relationship between the plaintiff and a disinterested stranger. The plaintiff was in the care of the defendant’s medical staff. They ought, as reasonable persons, to have foreseen that their inaction might entail harm for the plaintiff, and that they had the means to avert such harm. Nonetheless, they failed to prevent it by reasonable intervention. They neglected the moral and professional duty which rested on them to act reasonably towards the plaintiff.

5.6.2.3 Statutory obligation

An obligation to act may be imposed on a person by a specific statute.
An example here would be the obligation which regulations may impose on a medical officer to vaccinate persons who come for vaccination.

Further examples would be the duty inherent in the constitutional provision (s 27(3)) and the National Health Act 61 of 2003 (s 5) that no one be refused emergency treatment. (See 1.6, above, where the important Soobramoney case is also discussed.) The provisions of section 5 of the National Health Act 61 of 2003 prohibiting healthcare providers, health workers and health establishments from refusing a person emergency medical treatment are clearly applicable to healthcare personnel and hospitals in both the public and private sector (see 2.3 above). Clearly, the professional called upon to render emergency treatment in a serious, life-threatening situation requiring immediate action would not be entitled to refuse doing so unless there are compelling reasons for refusing or failing to act. Note that the wording of the relevant provision of both the Constitution and the National Health Act 61 of 2003 do not state the duty in the positive (ie healthcare providers must provide emergency care). The wording seems to imply that there must be a request for such assistance, albeit tacit (ie where a patient comes to a hospital or surgery in need of help).

**5.6.2.4 Contractual duty**

Where a person by agreement has taken certain obligations upon himself, he has to perform such obligations in order to avoid liability.

A legal duty of this kind can arise from a contract of employment.

An example is the physician in the service of a hospital authority. His contract with the authority obliges him to provide medical services in a certain section of the hospital (the casualty section, for example) where he must render medical aid to the victims of accidents or assaults who are brought in for treatment. (See 4.1.1.2 above.)

The scope of his duties depends on the terms of the contract of employment. If the contract restricts the physician’s duties to specific times or functions, failure to provide medical services to patients outside the times agreed upon, or to perform functions other than those agreed upon, will not normally make him liable.

It goes without saying that a duty to act arises in regard to patients with whom the physician has contracted to provide medical services. This is the ordinary obligation that every physician in private practice undertakes. In Administrator, Natal v Edouard 1990 (3) SA 582 (A) a hospital failed to perform the agreed tubal ligation during the course of a caesarean section. This rendered the hospital liable for the maintenance and support of a child born as a result of the failure. (See 11.3.3 en 11.3.4.)

We have already pointed out that it is a tacit condition of the agreement between a doctor and the patient which the former undertakes to treat, namely that he will do so with reasonable care and competence. The parties may of course come to a different agreement.
1. Discuss the legal principles in terms of which medical interventions are justified, in other words, which render such interventions lawful instead of unlawful.

2. Tungu visits Dr Nokuthula Chaza with a complaint of persistent and severe pain in his neck and shoulders. Dr Chaza diagnoses nerve root oppression (a “pinched nerve”) in his spinal column due to a bony growth. She proposes surgery to “free” the nerve. Dr Chaza warns Tungu of the possibility of disturbing a nerve root and the possible harmful consequences thereof. However, she does not mention the possibility of damage to the spinal cord itself, even though she knows that she would be operating within three millimetres of it. The risk of such damage is less than one per cent, but if the risk would materialise, the resulting injury could be very severe. Tungu consents to the operation which is carried out by Dr Chaza, a specialist surgeon, with due care and skill. Unfortunately the spinal cord is injured and Tungu suffers partial but irreversible paralysis. Can Dr Chaza be held liable on the grounds of lack of informed consent on the part of Tungu?

3. Dr Hava Hart, a cardiothoracic surgeon, returns to Gauteng after spending his holiday along the Garden Route. He takes the N 12 northwards through the Karoo. The vehicle in front of him is driven by Mrs Gaba Mabenz. Mabenz is typing an sms message while driving. This causes her to collide with an oncoming vehicle. The accident occurs between Meiringspoort and Beaufort West, approximately 40 km from Beaufort West. The driver of the oncoming vehicle, Mr Conrad (“Con”) Cussons, suffers serious concussion and lapses into unconsciousness. Dr Hart diagnoses a so-called cardiac tamponade in Con. This condition entails the accumulation of blood in the pericardial sac. The pericardial sac surrounds the heart, and the blood that collects in the sac exerts pressure on the heart. The blood urgently needs to be drained since it hampers the normal functioning of the heart’s pumping action. Dr Hart uses his pocket knife to penetrate Con’s thorax in order to drain the blood from the pericardium. As if this is not enough, Con is bleeding profusely from various open wounds sustained during the accident. Dr Hart starts to treat these wounds by staunching the bleeding. Apart from some bruises, Mrs Mabenz is unscathed, but her 10-year old son, Gozi, is seriously injured and unconscious. Dr Hart suspects that Gozi possibly suffered neck and spinal injuries. In the meantime the vehicle catches fire. Mrs Mabenz stands beside the vehicle screaming hysterically. Without Mrs Mabenz’ consent, Dr Hart carefully lifts Gozi out of the burning vehicle. By the time the emergency vehicles finally arrive on the scene, Mrs Mabenz’ vehicle has already been consumed by the fire, Con has already been saved, and Dr Hart has already treated Gozi for shock. However, in his attempt to save the child from the burning vehicle, Dr Hart caused further injury to Gozi’s spinal column with the result that Gozi is now a paraplegic.
(a) Can Dr Hart incur liability for the fact that Gozi is now a paraplegic?
(b) Can Dr Hart incur liability for assaulting Con Cussons?
(c) Suppose Dr Hart had not lifted a finger to help Con, but allowed him to bleed to death, can he incur liability for Con’s death?
(d) Suppose that Dr Hart had indeed successfully drained the cardiac tamponade, but that the knife wound started bleeding so profusely that Con succumbed as a result of blood loss from that wound. Can Dr Hart incur liability for failing to staunch the bleeding emanating from the knife wound?
(e) Suppose Con was HIV positive. Suppose further that Dr Hart was infected with HIV while attempting to stem Con’s bleeding, and suffered third degree burns to his arms and face in the course of his attempt to save Gozi from the burning vehicle. Can Dr Hart claim compensation from Mrs Mabenz or Con Cussons for the damages incurred as a result of the HIV infection and burns?
(f) Can Dr Hart claim fees from Con Cussons and Mrs Mabenz for the treatment administered?

4. Answer the following multiple-choice question. The possibility exists that a child and his or her parent(s) may differ with regard to their willingness to consent to an operation to be performed on the child. The Children’s Act 38 of 2005 contains detailed provisions on consent to an operation upon a child. Fanyana is 13 years old and comes to see Dr Messerschmidt, accompanied by his parents. He needs an operation on his abdomen. He is in Grade 7. Consider the following possibilities and identify the correct one. In terms of the Children’s Act 38 of 2005 ...

  (1) Dr Messerschmidt must honour Fanyana’s refusal to consent to the operation under all circumstances, even if his parents insist that the operation be performed.
  (2) Dr Messerschmidt may proceed with the operation as soon as Fanyana has given his consent, provided Dr Messerschmidt is of the opinion that Fanyana is sufficiently mature and possesses the mental capacity to appreciate the benefits, risks, social and other implications of the treatment.
  (3) Dr Messerschmidt has no other choice but to honour Fanyana’s parents’ refusal to assist him, even if Fanyana insists that the operation be performed.
  (4) Fanyana’s parents may refuse to consent merely by reason of their religious convictions, provided they can indicate that a medically acceptable alternative to the operation exists.

5. To which extent may (a) minor patients and (b) mentally ill patients independently give consent to medical treatment and operations?

6. Arrange the persons who may grant substituted consent in terms of the National Health Act 61 of 2003 in the correct order by writing the right letter next to the number indicating the order below: (a) parent, (b) adult child, (c) brother or sister, (d) spouse or live-in partner, (e) grandparent.

   1 ___ 2 ___ 3 ___ 4 ___ 5 ___

FEEDBACK

1. (a) The fundamental legal basis for medical interventions in most cases is consent, either by the patient herself or someone who is legally empowered thereto, on her behalf. There are other principles, however, that may also be applicable in other situations.
(b) There is the possibility of a statutory provision authorising medical intervention in the public interest, even against the will of the patient.

(c) A court order may authorise an intervention.

(d) In emergencies there are two grounds of justification which are important, namely necessity and negotiorum gestio (spontaneous agency/unauthorised administration). Note carefully the requirements of the different grounds of justification, and the circumstances where each finds application.

2. The doctor might argue that a one per cent risk is so negligible that the reasonable doctor would not have warned the patient of the existence of such a risk. In our opinion the criterion of "material risk" as applied in the Castelli case ought to be used, and not the criterion of the reasonable doctor. A court may find on the grounds of the relevant facts that Dr Chaza failed to duly inform Tungu.

3. (a) This is clearly an emergency situation. This case is complicated by the fact that the person who is able to consent on behalf of Gozi (Mrs Mabenz) was on the scene. However, this is a case of absolute emergency where Dr Hart had no other option than to remove Gozi without delay from the burning vehicle if he wished to save his life. We are of the opinion that Dr Hart acted reasonably in the circumstances and that he will therefore not incur liability. See 5.5.3.

(b) No. Con Cussons was unconscious, and Dr Hart can rely on negotiorum gestio. In your answer you should consider the requirements for the defence of negotiorum gestio. See 5.5.3.2.

(c) This question pertains to liability for an omission. The question whether Dr Hart had a legal duty to intervene should be investigated. The general criterion for determining whether such a duty exists is the boni mores. Always discuss the general criterion as the specific instances that have crystallised in practice are merely more concrete manifestations of this criterion. Also note the considerations listed in 5.6.1. In considering the question whether the boni mores requires a doctor to intervene, a court may possibly take into consideration the ethical prescripts of the HPCSA. Therefore, you should also consider the ethical prescripts. This case may possibly be categorised as one where a statutory provision requires the doctor to perform a positive act. See 5.6.2.3, and discuss section 27(3) of the Constitution and section 5 of the National Health Act 61 of 2003.

(d) While (c) above deals with a mere omission to act, this question deals with an omission on the part of the doctor to treat a dangerous situation that he has created himself. Dr Hart stabbed a hole in Con Cusson's thorax in order to drain the cardiac tamponade, but in so doing he created another dangerous situation, namely a stab wound. Dr Hart had to ensure that the danger resulting from his act was averted. Therefore, he had to take steps to staunch the bleeding emanating from the stab wound. This is an instance of a commissio per omissioem. Remember that a person who administers another's affairs without authorisation is obliged also in terms of the rules applicable to negotiorum gestio to complete what he has begun. However, take a step back and consider the bigger picture for a moment while taking into account all the surrounding circumstances. Poor Dr Hart found himself in a situation where it was impossible for him to give simultaneous attention to all the victims of the accident. In these circumstances he might for instance have decided to rescue Gozi from a sure death by fire first before attending to the stab wound. If, with regard to the circumstances, he acted reasonably in determining treatment priorities, he ought not to incur liability. In fact, in our opinion he deserves an award for bravery!
(e) The gestor has the right to recover damages from the person who caused the emergency in a negligent or intentional manner (Mrs Mabenz). See 5.5.3.2. If there was contributory negligence on Dr Hart’s part (e.g., if he failed to wear surgical gloves he had at hand in order to avoid being infected with HIV), apportionment of damages will be ordered in accordance with his relative contribution to the extent of the damages.

(f) Indeed, provided that he had the intention to claim such fees all along. See 5.5.3.2.

4. The correct answer is (4).

(1) Fanyana complies with the age requirement as stipulated in the Children’s Act 38 of 2005, but that alone is insufficient. Fanayana can only consent to an operation if he is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation (s 129(3)). Fanayana may refuse the operation only if he is capable of consenting to the operation.

(2) Although Fanayana’s consent is required where he is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation, it is insufficient in the case of an operation (as opposed to medical treatment). Fanayana must be assisted by his parent or guardian (s 129(3)). Therefore, Dr Messerschmidt must first ensure that Fanayana’s parent has given permission on the prescribed form. See 5.4.2.1.

(3) If Fanyana’s parents unreasonably refuse duly to assist him in respect of consent to the operation, Dr Messerschmidt may approach the Minister for consent (s 129(7)). Note that the Minister can also be approached for consent if Fanayana unreasonably refuses to consent (s 129(8)).

(4) Read section 129(10) very carefully. It stipulates, inter alia, that no parent may refuse to assist a child in terms of subsection (3) by reason only of religious beliefs, unless that parent can show that there is a medically acceptable alternative to the surgical operation concerned.

5. Minors and mentally ill persons are under certain circumstances incapable of independently consenting to a medical intervention. Study 5.4.2 and 5.4.3 carefully to determine the circumstances under which they do not need anybody else’s assistance to consent to a medical intervention.

6. 1(d), 2(a), 3(e), 4(b), 5(c)
<table>
<thead>
<tr>
<th>Glossary Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Adrenaline</td>
<td>Also called epinephrine. An important hormone secreted by the adrenal glands. When the body is activated into its fight or flight status by a sudden stressor or emergency, the sympathetic nervous system is mobilised, causing the blood sugar level to rise, blood vessels to constrict, heartbeat to increase, blood pressure to rise, and the blood of the (temporarily) non-essential organs such as the bladder and intestines to be re-routed to the brain, heart and skeletal muscles. Adrenaline is secreted to prolong and strengthen the fight or flight response. Adrenaline <em>inter alia</em> impacts on the heart rate and metabolism, and plays a role in dilating the bronchioles and blood vessels of the lungs. Adrenaline can be injected to relieve asthma; is used during surgery to stem blood loss by causing the cutaneous blood vessels to contract; is used in local anaesthetic solutions such as are used in dentistry to prolong the effect of the anaesthesia. In anaphylactic shock (a severe allergic reaction) the bronchioles contract (the tongue may also swell up) so that breathing becomes difficult. The sudden dilatation of the blood vessels and fluid loss from the bloodstream may cause circulatory collapse. Adrenaline is administered to reverse these histamine-mediated effects.</td>
</tr>
<tr>
<td>Amputation</td>
<td>Cutting off a limb or part thereof, a breast, or other body part which protrudes.</td>
</tr>
<tr>
<td>Anatomy</td>
<td>Science which studies the form (morphology) and structure of the body and its constituent parts.</td>
</tr>
<tr>
<td>Antihistamines</td>
<td>Drugs which inhibit the effect of histamine in the body by blocking histamine receptors. These receptors may cause allergic reactions such as pruritus (itching) and urticaria (nettle-rash; round, red, itchy hives on the skin; may differ in size) when stimulated. Histamine is present in all tissue and causes dilatation of the blood vessels and contraction of smooth muscle tissue, eg in the lungs.</td>
</tr>
<tr>
<td>Assisted Care, Treatment and Rehabilitation</td>
<td>For the purposes of the Mental Health Care Act 17 of 2002, the provision of healthcare interventions to people incapable of making informed decisions due to their mental health status and who do not refuse the health interventions.</td>
</tr>
<tr>
<td>Autonomy</td>
<td>In the context of medical law the right to selfdetermination over your own body; to decide whether you want to undergo a medical intervention or not. In the bio-ethics it means selfdetermination free from both controlling intervention by others and personal limitations preventing meaningful choices (eg insufficient knowledge; false arguments). Autonomous decisions thus are decisions resulting from consideration and choices by rational people, because rational people fulfil the criteria for deciding what is best for them. An autonomous person has the ability to consider his or her own objectives and to act in accordance with this consideration. Synonym: selfdetermination. From the Greek: <em>autos</em> (self) + <em>nomos</em> (law).</td>
</tr>
<tr>
<td>Term</td>
<td>Description and Definition</td>
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<tr>
<td>---------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>boni mores</strong></td>
<td>Literally: “the good morals”. Freely translated: “the juristic notions of society”. Pronunciation: “BOW-knee MOW-rays”.</td>
</tr>
<tr>
<td><strong>cardiac tamponade</strong></td>
<td>The accumulation of fluid, usually blood, in the pericardial sac. The pericardial sac is a conical multi-layered sac-like membrane which surrounds the heart and the roots of the large blood vessels. Cardiac tamponade is a life-threatening medical emergency since the fluid that collects in the pericardial sac exerts pressure on the heart and impedes the normal functioning of the heart. Owing to the compression of the heart, the ventricles (the lower chambers of the heart) cannot properly fill with blood, which means that the heart cannot pump sufficient blood to the lungs and the rest of the body. If cardiac tamponade is left untreated, it may result in low blood pressure, shock and death. Under ideal circumstances the blood is drained with the aid of a hollow needle or catheter in order to relieve the pressure.</td>
</tr>
</tbody>
</table>
| **care-giver**            | For purposes of Children’s Act 38 of 2005, “Care-giver” means any person other than a parent or guardian, who factually cares for a child and includes –  
  - a foster parent;  
  - a person who cares for a child with the implied or express consent of a parent or guardian of the child;  
  - a person who cares for a child whilst the child is in temporary safe care;  
  - the person at the head of a child and youth care centre where a child has been placed;  
  - the person at the head of a shelter;  
  - a child and youth care worker who cares for a child who is without appropriate family care in the community; and  
  - the child at the head of a child-headed household. |
<p>| <strong>cerebrospinal fluid</strong>   | Clear, colourless, salty fluid; fills the subarachnoid space (between the arachnoid <em>mater</em> or middle layer of cerebral membrane and the <em>piamater</em> or layer of the meninges closest to the brain) and the system of cavities known as the ventricles around and inside the brain and spinal cord. One could say that the brain floats in this fluid. It serves as a “cushion” or buffer for the cortex of the brain, and softens contact with the skull when the head is suddenly moved. |
| <strong>circumcision</strong>          | Of a male person: removing part or the whole of the foreskin. Of a female person: wide concept which may refer to different forms of genital excision, varying from removal of the clitoral foreskin, to removal of the clitoris, <em>labia minora</em> and parts of the <em>labia majora</em>. |
| <strong>claudication</strong>          | Pain as result of poor circulation due to clogging of veins. |
| <strong>cochlea</strong>               | Shell-like spiral-shaped part of inner ear. Auditive part of the inner ear, ie involved in reception and analysis of sound. |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>cochlear nerve</strong></td>
<td>Sensory nerve in the head transmitting messages of acoustic energy impinging on the membrane of the eardrum from the cochlea in the inner ear to the brain.</td>
</tr>
<tr>
<td><strong>cochlear vestibular neurectomy</strong></td>
<td>A designedly destructive intervention aimed at severing both cochlear- and vestibular nerves.</td>
</tr>
<tr>
<td><strong>coma</strong></td>
<td>State of deep unconsciousness from which a person cannot be woken up. Can be the result of trauma, illness, or an ingested poison or poisonous substance formed in the body.</td>
</tr>
<tr>
<td>**commissio per omissi-<strong>onem</strong></td>
<td>Where the perpetrator creates a potentially dangerous situation through a positive act, and afterwards fails to take precautions to prevent the danger. Relevant in cases of liability due to omission. Pronunciation: “co-MISS-ee-oh PÉR oh-miss-ee-OH-nehm”.</td>
</tr>
<tr>
<td><strong>complication</strong></td>
<td>Pathological process or event occurring during an illness, being a non-essential part of the illness, although it may develop from the illness or from an independent cause. Thus an additional complicating pathological phenomenon. Illness or injury developing during treatment of an existing malady. Adverse pathological process or event following on medical treatment or procedure.</td>
</tr>
<tr>
<td><strong>contra bonos mores</strong></td>
<td>Literally: “against the good morals”. More freely: “contrary to the juristic notions of society”. Note that it is not “contra boni mores” but “contra bonos mores”. The good morals are indeed the boni mores, but the word bonos is here in a different case, the accusative case, and therefore has a different ending. Pronunciation: “KON-trah BOW-nos MOW-rays”.</td>
</tr>
<tr>
<td><strong>court order</strong></td>
<td>In this context a ground of justification where a specific intervention on a patient, which would otherwise be unlawful, is authorised by a court order.</td>
</tr>
<tr>
<td><strong>crimen injuria</strong></td>
<td>Criminal infringement of a person’s dignity or privacy. Pronunciation: “CREE-men in-YOU-ree-ah”.</td>
</tr>
<tr>
<td><strong>delirium</strong></td>
<td>An altered, befuddled state of consciousness characterised by confusion, withdrawal, disorientation, confused thought patterns, affected memory, defective perception (illusions and hallucinations), explicit hyperactivity, agitation and overactivity of the autonomous nervous system. May be caused by several toxic structural and metabolic diseases (ie high fever and alcohol abuse).</td>
</tr>
<tr>
<td><strong>diagnosis</strong></td>
<td>Ascertaining the nature of a disease, injury or birth defect according to its characteristics and symptoms.</td>
</tr>
<tr>
<td><strong>dominus</strong></td>
<td>Literally: “lord”. Here the person in whose interest the gestor acts in negotiorum gestio. Pronunciation: “DO-me-noos”.</td>
</tr>
<tr>
<td><strong>ear, nose and throat specialist/surgeon</strong></td>
<td>Medical specialist in diagnosing and treatment of illnesses of the ear, nose and throat as well as the adjacent structures of the head and neck. Also called an otolaryngologist.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>electroshock therapy</td>
<td>Form of treatment of mental illness. Electrodes are attached to the head, and an electric current sent through the brain, eliciting convulsions (muscle spasms). Currently done under anaesthesia; patient is given muscle relaxants to prevent fractures.</td>
</tr>
<tr>
<td>endotracheal tube</td>
<td>Tube carrying oxygen placed in patient’s windpipe (trachea) during operation.</td>
</tr>
<tr>
<td>functional endoscopic sinus surgery</td>
<td>Minimally invasive intervention whereby sinus cavities (ostia) are opened to repair sinus ventilation and prevent infection. An endoscope is a long, flexible tube with a light (and video camera) at one end. Inserted through a body opening such as the nose, or through a small incision. Pictures are relayed to an external television screen.</td>
</tr>
<tr>
<td>gestor</td>
<td>Literally: “one who brings”. Here the person acting on behalf of another in negotiorum gestio. Pronunciation: “GHES-tor”.</td>
</tr>
<tr>
<td>ground of justification</td>
<td>Defence which, if successful, excludes the apparent unlawfulness/wrongfulness of an act. Note that not all defences are grounds of justification, but all grounds of justification are defences. There are also defences which exclude the further element of liability, namely culpability (sometimes called fault or mens rea.)</td>
</tr>
<tr>
<td>idiosyncratic reaction</td>
<td>Abnormal, unpredictable, adverse reaction, specific to an individual. An individual (allergic) reaction to a specific substance or medication.</td>
</tr>
<tr>
<td>impacted wisdom teeth</td>
<td>Wisdom teeth are the third molars at the back of the mouth. Sometimes there is insufficient space for them to erupt or grow normally. In dental terminology, a wisdom tooth that has failed to fully emerge into its expected position is called an impacted wisdom tooth. May cause pain, damage to other teeth, and other dental problems.</td>
</tr>
<tr>
<td>in loco parentis</td>
<td>Literally: “in the place of the parent”. Pronunciation: “IN LOW-co pa-REN-tis”.</td>
</tr>
<tr>
<td>involuntary care, treatment and rehabiliation</td>
<td>For the purposes of the Mental Health Care Act 17 of 2002, the provision of health interventions to people incapable of making informed decisions due to their mental health status and who refuse health intervention but require such services for their own protection or for the protection of others.</td>
</tr>
<tr>
<td>laminectomy</td>
<td>Excision of the whole or part of the vertebral bone called the lamina.</td>
</tr>
<tr>
<td>lower alveolar nerve</td>
<td>Branch of the mandibular nerve which is the third branch of the trigemenial nerve. The lower alveolar nerve runs through the lower jaw or mandibulum. It branches off to innervate the bottom pre-molars, canines and incisors, as well as the chin, gums and lower lip.</td>
</tr>
<tr>
<td>lower sacral nerves</td>
<td>Nerves of the sacrum, a bone at the lower end of the spine.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>lucida intervalla</td>
<td>Literally: “clear intervals or pauses”. Singular: <em>lucidum intervallum</em>. Refers to a moment when an otherwise mentally ill person is temporarily clear-headed or able to think rationally. Pronunciation: “LOOK-key-dah in-ter-VAL-lah”.</td>
</tr>
<tr>
<td>material risk</td>
<td>Study definition of material risk as given in <em>Castell v De Greef</em> 1994 (4) SA 408 (C).</td>
</tr>
<tr>
<td>minor</td>
<td>Person under the age of 18 years.</td>
</tr>
<tr>
<td>necrosis</td>
<td>See “tissue necrosis”.</td>
</tr>
<tr>
<td>necessity</td>
<td>Ground of justification for an act performed by a person to protect that person’s own or another’s legally recognised interests, or the public interest, against an already present or immediately threatening danger which cannot be warded off in any other way. However, the person must not be legally obliged to endure said danger, and the interest that is protected by the protective act must not be disproportionate to the interest violated by the act.</td>
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<tr>
<td>negotiorum gestio</td>
<td>Also: “spontaneous agency” or “unauthorised administration”. In the context of medical law, the ground of justification whereby one person, the gestor, acts on behalf of the other, the dominus, in circumstances where such action is urgently needed, the dominus is unaware that his or her interests are being protected, and did not authorise such action. Pronunciation: “neh-go-tee-AW-room GUESS-tee-oh”.</td>
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<tr>
<td>neurosurgeon</td>
<td>Surgeon specialising in operations of the brain, spinal cord, spine and peripheral nerves.</td>
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<tr>
<td>otolaryngologist</td>
<td>See “ear, nose and throat specialist”.</td>
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<tr>
<td>paternalism</td>
<td>Exercising control over or care of subordinates without giving them any say in their own affairs. Medical paternalism is embodied in the saying: “The doctor knows best.” Where a medical practitioner acts in accordance with what he or she believes is in the patient’s best interest, while these actions do not coincide with the patient’s wishes, views or beliefs. Paternalism is thus the conviction that a healthcare practitioner has to protect and promote the patient’s interests, even if these actions contravene the patient’s right to autonomous decision-making.</td>
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<tr>
<td>phenol block</td>
<td>Neurolytic procedure whereby hydroxybenzene (phenol) is injected to numb a specific nerve permanently. Sometimes used to block nerve impulses in cases of chronic pain.</td>
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<tr>
<td>prima facie</td>
<td>At first sight. Pronunciation: “PREE-ma FAH-key-ay”.</td>
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<tr>
<td>prognosis</td>
<td>Forecast of the probable course and/or outcome of an illness. From the Greek <em>pro</em> (before) + <em>gignosko</em> (to know).</td>
</tr>
<tr>
<td>psychiatry</td>
<td>Medical specialist field concerning the diagnosis and treatment of mental illness.</td>
</tr>
<tr>
<td>risk</td>
<td>The probability of a result ensuing. In this context, the possibility of an unfavourable result ensuing.</td>
</tr>
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</table>
spontaneous agency  
See *negotiorum gestio.*

statutory authority  
A *ground of justification* where performing a specific intervention without the patient's consent, which would otherwise be unlawful/wrongful, is authorised by legislation.

steal syndrome  
For purposes of the present discussion – *claudication* in one area as a result of diversion of blood from an artery supplying that area with blood to another blood vessel. This would occur if the diversion results in insufficient blood supply to that area.

substituted consent  
Consent by another person on behalf of a patient who is unable to give consent.

therapeutic privilege  
Withholding information which otherwise would have had to be revealed to fulfil the doctrine of informed consent, in circumstances where revealing such information is not in the patient's best interests.

thyroid  
Bilobular endocrine gland found in all vertebrates; situated on both sides of the trachea (windpipe) in humans. Manufactures different hormones which affect metabolism and body growth. May enlarge through various causes, eg lack of iodine in the diet, or elevated level of thyroid-stimulating hormone (TSH) from pituitary gland. If enlarged to such extent that it puts pressure on other structures in the neck (trachea, oesophagus, blood-vessels), surgical removal might be indicated.

tinnitus  
Ringing or buzzing in the ear, occurring without any external cause or stimulus.

tissue necrosis  
Pathological necrosis of one or more cells, or part of the tissue of an organ following irreversible damage to the tissue as a result of infection, trauma, interference with the blood flow, or chemical injury.

tracheotomy  
A tracheotomy is a surgical procedure where a hole is made in the neck through the trachea (wind pipe) to relieve obstruction in the airway and ensure proper air supply. A rubber, metal or plastic tube is attached to the stoma (artificial opening in throat) after a tracheotomy.

vascular surgeon  
Surgeon specialising in the surgical management of diseases of the arteries, veins and lymphatic systems, with the exception of the intracranial arteries (inside the cranium or bony cavity or top part of the skull enclosing the brain) and coronary arteries (blood vessels supplying oxygen-rich blood to heart muscle).

vestibular nerve  
A sensory nerve that transmits information about spatial orientation from semicircular canals in ear to brain; plays an important role in maintaining balance and coordination.

vestibulum auris  
Enterance or vestibule of *cochlea.* Pronunciation: "ves-TI-boo-loom OW-rees".
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td><em>volenti non fit iniuria</em></td>
<td>Literally: “no injustice is done to him who is willing (or gives his consent)”. Legal maxim embodying consent as ground of justification. Pronunciation: “vaw-LEN-tee NON FIT in-YOU-ree-ah”.</td>
</tr>
<tr>
<td>voluntary care, treatment and rehabilitation</td>
<td>For the purposes of the Mental Health Care Act 17 of 2002, providing healthcare interventions to a person who consents to such interventions.</td>
</tr>
<tr>
<td>XDR-TB</td>
<td>Abbreviation for “extensive drug-resistant tuberculosis”. TB is usually treated with a combination of certain drugs which have to be used for six months. If patients receive insufficient treatment, either because of not completing the full course, or not taking the drugs correctly, or using drugs of inferior quality, MDR-TB (multi-drug-resistant TB) may develop, meaning resistance to multiple drugs. The drugs used in treating this form of TB are much more expensive, and treatment also lasts longer than for normal TB. XDR-TB is TB that has developed resistance to some of these expensive drugs used to treat MDR-TB.</td>
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Medical intervention aimed at cure, anaesthesia or euthanasia

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   6.3.1 Prophylactic (preventive) measures
   6.3.2 Curative objective

Activities
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Learning outcomes

When you have completed this study unit, you should be able to

- distinguish between therapeutic and non-therapeutic procedures
- explain the legal principles (deriving from common law or statutory law) which apply to a range of medical procedures such as anaesthesia, palliative pain relief, euthanasia, prophylaxis, and anatomical donation

6.1 Introduction

In previous study units we discussed the grounds of justification relating to medical treatment. We indicated that consent cannot be raised as a defence justifying each and every type of treatment undertaken by a medical practitioner. In this study unit we discuss specific medical interventions, and find out whether they have legal sanction.

Medical intervention can occur in respect of ill or injured persons, but also in respect of healthy persons. However, the objectives of the respective interventions usually differ.

The following are the objectives for interventions on ill persons:

- healing, relieving symptoms, or anaesthesia/relieving pain (therapeutic interventions)
causing the death of seriously ill or injured patients where there is no hope of recovery, in order to bring an end to the person’s misery (non-therapeutic interventions)

Interventions on healthy persons have the following objectives:
- to prevent disease (prophylaxis)
- to promote medical science (non-therapeutic)
- realising procreation needs (non-therapeutic)

Certain interventions may be performed on both ill and healthy persons, such as scientific experimentation, castration and cosmetic procedures. The objectives for such interventions naturally differ from case to case. In addition there are also fruitless interventions where the objective is not healing, but something else. Procedures to change a person’s sex to be in line with his or her gender identification (sex changes) are not easily categorised.

In view of the different considerations when evaluating the different interventions, it is preferable to discuss them separately, and for that reason we differentiate between interventions on ill persons and interventions on healthy persons.

We first consider medical interventions on ill persons with the objective to heal, anaesthetise, or bring about death to end suffering. Thereafter we discuss prophylactic interventions on healthy persons, and removal of tissue and gametes from both living and deceased persons. The main question here is whether and to what degree the specific intervention is legally recognised.

6.2 Interventions on ill persons

6.2.1 Curative objective

The lawfulness of an operation or treatment undertaken with the aim of effecting a cure is beyond any doubt, provided that a ground of justification (such as consent or negotiorum gestio) is present.

It need hardly be stressed that an intention to cure must be present. If the intervention occurs without this aim, and by happy coincidence it has the effect of curing the victim of his disease, it is not necessarily justifiable on the grounds of consent. (In criminal law, this fortuitous result may perhaps constitute a mitigating circumstance, and in the law of delict it may affect the quantum of damages.)

Everyday life is full of instances of lawful medical intervention by professionally unqualified persons. However, in the case of drastic treatment, it must take place in accordance with the principles of medical science, and in the case of treatment which is not of a drastic nature, at least in accordance with the rules of everyday hygiene. (In emergency situations the intervention of unqualified persons may however be justified, depending on the situation.) If the treatment satisfies these requirements, its ultimate success or failure is not a factor. No medical operation or treatment is assured of absolute success. Medical science is also subject to limitations, and even well-tested remedies can fail in a particular case. The possibility of success might be comparatively slight but the treatment may nevertheless be lawful. Even treatment undertaken by experienced medical practitioners who apply recognised methods, is frequently experimental to a certain extent.

Consent to reckless experiments with no consideration for recognised practices, however, is undoubtedly contra bonos mores and the treatment is consequently unlawful. Human life and
physical integrity are regarded too highly to become the objects of dangerous experimentation (see study unit 1). However, a few limitations apply here. Brief temporary injuries of an experimental kind aimed at effecting a cure ("therapeutic innovation") must be regarded as lawful. Infliction of serious harm, on the other hand, is forbidden. In order to be lawful, experimentation must to a certain extent be unavoidable. If other recognised procedures or methods of treatment can be effective, there can be no possible justification for applying those which are unknown. If the experiment can be satisfactorily performed on an animal, it would undoubtedly not be lawful to attempt it on a human being. Where, on the other hand, the patient cannot be saved from certain death by any other known means, even a dangerous experiment with little chance of success will be fully justified

On human experimentation, see our discussion in 7.7.

6.2.2 Objective: anaesthesia

Administering anaesthesia in order to minimise the patient’s pain and discomfort during an operation is undoubtedly lawful and has become an important form of medical treatment. It may even constitute negligence if anaesthesia is not administered properly and the patient still endures pain. If a muscle relaxant is given before the operation, the patient will be unable to indicate that he or she still feels pain.

Administering drugs to relieve pain is also lawful. (Abuse may of course occur, but it is controlled by strict regulation of medicines and related substances.) Palliative pain treatment is also lawful where there is no hope of a cure and therapeutic treatment has also been discontinued, as for example in the final stages of cancer, where this is common practice. The very substances used for pain relief may cause the death of the patient. In this regard we speak of the "double effect" of such drugs. Will administering such drugs in circumstances where the patient's death will be hastened be regarded as lawful? According to the decision in R v Makali 1950 (1) SA 340 (N) 344 hastening of the death is still causing it. The court said:

The true enquiry is whether the deceased would have died when he did but for the [accused's] unlawful act. If this enquiry gives an affirmative answer, [accused] is responsible for the death because he caused it to take place when it did, that is to say because he hastened it.

Williams (285 et seq) is of the opinion that a physician's conduct is not unlawful in the following instances:

(1) A patient is suffering from an incurable disease accompanied by excruciating pain. The physician administers the minimum dosage of drugs necessary to make the pain endurable knowing that such minimum dosage will probably also cause death.

(2) A patient is suffering from a painful and incurable disease and a drug is administered. Because of the resistance consequent upon the habitual administering of the drug, steadily increasing doses have to be administered. This means that unless the patient dies beforehand owing to another cause, a point must be reached when the dosage becomes lethal.

We share this view. Kahn E (The sanctity of human life (1984) 24 at 25) is correct in pointing out that "[t]he doctor who, in genuinely and reasonably attempting to relieve the pain of his patient, indirectly hastens the death of his patient, is not guilty of murder, because his conduct was not unlawful". (See also Clarke v Hurst NO 1992 (4) SA 630 (D) 656 H–I.) The doctor's intention in this situation is not to end the patient's life, but to relieve the patient's suffering.
6.2.3 Objective: death to relieve suffering (euthanasia)

6.2.3.1 Active euthanasia

The expression “active euthanasia” is used to refer to the case where someone commits an intentional act to end the life of a person suffering from an incurable disease, with the objective of relieving the person’s suffering. When active euthanasia occurs with the consent or on request of the patient, it is called “voluntary active euthanasia”. On the other hand “involuntary active euthanasia” occurs where the patient’s life is ended without taking his or her own wishes into consideration, or even against the person’s direct wishes, and irrespective of whether the person is capable of giving consent. However, the motive is still ending the patient’s suffering.

The causing of death by a positive action is unlawful in principle. Consent to homicide is no defence in our law. See *R v Peverett* 1940 AD 213; *S v Robinson* 1968 (1) SA 666 (A). In *R v Dawidow* (unreported; a concise report by Van Dyk HP appears in 1956 *THRHR* 286) a man was accused of murder after having shot his painfully suffering mother in hospital with a revolver in order to release her from her suffering. She had repeatedly said that she would rather be dead. It was submitted in defence that the accused was *doli incapax* (lacked criminal capacity). The jury found the accused not guilty. As Van Dyk rightly shows, there was no recognition here of euthanasia as a lawful procedure.

Compare with this *S v De Bellocq* 1975 (3) SA 538 (T), a case of euthanasia where there could, however, be no request or desire on the part of the sufferer. A young married woman had brought her first child into the world. Shortly after the birth it became apparent that the child was suffering from an incurable disease, toxoplasmosis, the effect of which is that the sufferer’s brain becomes irreparably damaged. The child would have led a completely “vegetative” existence and would probably not have lived for any length of time. The mother, a medical student, was au fait with all the facts and implications. In a state of emotional shock and deep depression she killed the child by drowning it in a washbasin. She was accused of murder and found guilty but was not sentenced. The judge merely imposed an order in terms of section 349 of the Criminal Procedure Act then in operation, without requiring recognisances.

Active euthanasia, therefore, is unlawful whether it takes place at the request of the sufferer or otherwise. If a medical practitioner were to take positive steps – were, for example, to administer an overdose of drugs – in order to cause immediate death or to hasten death considerably, he would consequently be guilty of murder. See *S v Hartmann* 1975 (3) SA 532 (C). In this case a medical practitioner took the life of his father who had been suffering severely. The father, an old man of 87, had suffered from cancer of the prostate for some years. The cancer later spread to other parts of his body. The deceased was bedridden and emaciated when, at a certain stage, further complications ensued, including a pulmonary embolus (blood clot in the lung). He was treated with pain-killing drugs and it seemed that he was already moribund. A nurse administered a considerable dose of morphine to the deceased on the instructions of the accused. The accused himself later administered further morphine as well as a dose of pentothal (a drug used in

**HINT:** Note that in all the cases mentioned the charge was murder, and that De Bellocq and Hartmann were also found guilty of murder. Students often write that the relevant charge was culpable homicide. That is wrong, because culpable homicide requires negligence, while murder requires intention. Intention and motive should not be confused with each other. Even though an act is committed with a good motive (ie to end a person’s severe suffering) there may still be intention.
anaesthesia). The deceased died within minutes of the administration of the pentothal. A post mortem revealed that the pentothal caused his death. The court held that the accused was guilty of murder. In his judgment Van Winsen JP pointed out that it was unlikely, on the evidence before the court, that the father had expressed a wish to die. Even were that the case, however, it would not have constituted a defence. The judge held that there were strong mitigating factors present and he sentenced the accused to a term of imprisonment of one year, the entire period being suspended with the exception of the detention of the accused until the rising of the court.

In respect of positive conduct by a doctor, we have thus far only considered administering of drugs by the doctor himself. What would the situation be where the doctor does not himself administer the drug, but makes it available to the patient, and the latter then administers the drug? Where administering of the substance is lawful, there is in principle no difference between administering and supplying. However, the question arises whether it would make a difference where administering of the drug is unlawful. (In study unit 9, where we discuss murder and culpable homicide, we will return to this question. In the present study unit we are concerned with cases where the doctor consciously helps to hasten the patient’s death with the objective of relieving suffering. The discussion in study unit 9 also cover cases where that is not the doctor’s motive.)

This brings us to the question of assisted suicide, which refers to the situation where someone commits suicide with the help of another person, for example a family member, friend, or doctor (which concerns us here). Suicide is not regulated by law, but the common-law crime, murder, covers cases where a person helps another to take his own life. Murder is defined as the unlawful and intentional causing of another person’s death, and any person who in any way contributes to another’s death may be found guilty as perpetrator of murder. The most problematic element of this crime in the case of helping someone to commit suicide is causation, because the suffering person in this case commits the final suicidal act himself. The sufferer is thus responsible for the last link in the causal chain of events. In Ex parte Minister van Justisie: In re Grotjohn 1970 (2) SA 355 (A) the court however found that a person who consciously encourages another person to commit suicide, or in any way is of assistance in this regard, would not necessarily avoid liability on the grounds that the required causal connection (causal link or nexus) was absent. It is therefore conceivable that a person may thus indeed incur liability in the right circumstances.

6.2.3.2 Passive euthanasia

Qedusizi’s mother, Celukuthula, is seriously injured in a car accident. Her brain injuries are so serious that she has to be kept alive with a heart-lung machine. Qedusizi is very upset to see his mother, who was always so full of life, lying in this state for weeks on end. Qedusizi’s mother is a widow and he is her only child. He comes to see you to find out whether he may ask the doctor to switch off the machines. He has decided that he never wants to be in such a situation. He has heard about a “living will” where one can state that if one is ever in such a situation, the machines should be switched off. He asks you whether it is a good idea to have such a living will.

We now know that active euthanasia describes the situation where a person deliberately takes steps to put an end to the life of a person who is suffering from an incurable disease. As opposed to
In this situation, there is the situation where a person is kept alive artificially by medical means, and the attending doctors decide that there is no purpose in continuing resuscitative or life-sustaining measures. Where such treatment is discontinued, resulting in the patient’s death, the term "passive euthanasia" is sometimes used. In other words, passive euthanasia is effected through an omission (in contrast to active euthanasia). Death thus occurs due to the underlying illness of the patient. (Some people however argue that the use of the word "euthanasia" in this context is altogether unacceptable.) Difficult ethical, legal and religious questions arise in regard to this situation. The debate around these issues is known as the “right to die” debate.

The first decision of a South African court on the “right to die” was handed down in the case of Clarke v Hurst NO 1992 (4) SA 630 (D). It is a landmark judgment which clarified several major legal issues relating to the withdrawal of life-sustaining treatment in a case of terminal illness and, particularly, in cases of patients who are in a persistent vegetative state (PVS).

The case concerned the tragic fate of Dr Clarke, a well-known Natal medical practitioner and politician, who in his lifetime had been a member of the SA Voluntary Euthanasia Society and before his last illness had signed the living will. A living will is an advance directive (instruction made before death) saying that should the person who made this will ever suffer from an incurable disease or injury which cannot be treated successfully, life-support treatment must be withheld so that the person may die in a natural way.

The 63 year old was undergoing epidural treatment when he suddenly suffered a drop in blood pressure and went into cardiac arrest. His heartbeat and breathing ceased. Resuscitative measures were instituted but by the time that his heartbeat and breathing were restored he had suffered serious and irreversible brain damage due to prolonged deprivation of oxygen to the brain (cerebral anoxia). He had become deeply comatose and remained in that condition permanently.
In the judgment of the court Thirion J commented on certain public statements made by Dr Clarke in 1983:

These statements undoubtedly stemmed from a settled, informed and firmly held conviction on [his] part that should he ever be in the condition in which he has been since the cardiac arrest, no effort should be made to sustain his life by artificial means but that he should be allowed to die.

Some three years after the tragedy that befell Dr Clarke, his wife approached the court for an order appointing her as curatrix of her husband’s person, with powers inter alia to withhold agreement to any medical treatment for her husband, and to authorise the discontinuance of any treatment, including any naso-gastric or other non-natural feeding regime or like regime for the hydration of the patient.

The Attorney-general of Natal opposed the application on a number of grounds. One of the main grounds of opposition was summed up by the judge thus:

The discontinuance of the artificial feeding would hasten the patient’s death and would thus be a cause of it and as the applicant foresees death as a probable result of the discontinuance of the artificial feeding, she would in law be liable for having unlawfully killed the patient.

The judge refused to uphold that argument. The issues in the present case, the judge said, “can only be approached after a thorough evaluation of the patient’s physical and neurological deficits and the extent of the biological and intellectual life which still remains to him”.

The specialist physicians and neurologists who had examined the patient were in agreement that he was in a persistent vegetative state because of the extensive damage to the cerebral cortex – that part of the brain which is responsible for intellectual function and cognitive awareness. They also agreed that the damage was irreversible and that no improvement was possible. It is to be noted, however, that Dr Clarke was not brain dead.

The term “persistent vegetative state” describes a neurological condition where the subject retains the capacity to maintain the vegetative part of neurological function but has no cognitive function. In such a state the body is functioning entirely in terms of its internal controls. It maintains digestive activity, the reflex activity of muscles and nerves for low-level and primitive conditional responses to stimuli, blood circulation, respiration and certain other biological functions, but there is no behavioural evidence of either self-awareness or awareness of the surroundings in a learned manner. The patient did not experience pain or discomfort because he had lost the capacity to experience these sensations. “But,” said the judge,

[t]here is ... no doubt that legally the patient is still alive; nor is death imminent. His life expectancy is uncertain. The discontinuance of naso-gastric feeding and any other form of nourishment is bound to lead to the termination of such life as the patient still has.

In deciding the case, the judge was not prepared to give absolute recognition to an advance directive (eg in the form of the living will). (It is relevant to observe here that we do not have legislation in South Africa, as yet, regulating advance directives or durable powers of attorney.)
In Clarke the patient’s curator ad litem argued as follows:

An adult of full legal competence has, while of sound mind, an absolute right to the security and integrity of his body. In the exercise of that right he is entitled to refuse to undergo medical treatment, irrespective of whether such refusal would lead to his death ... . Where, as in present case, such a person while he is of sound mind, has directed that should he lapse into a persistent vegetative state with no prospect of recovery, he should be allowed to die and that he should not be kept alive by artificial means, then if he does lapse into such a state, there is no reason why a curator appointed to his person should not have the power to give effect to his direction.

Thirion J refused to uphold that contention, though, ruling as follows:

The fallacy of counsel’s argument lies in the fact that in our law the curator personae is at all time under a duty to act in the best interests of the patient and not necessarily in accordance with the wishes of the patient; the wellbeing of the patient being the paramount consideration. In our law the Court would not simply weigh the patient’s interest in freedom from non-consensual invasion of his bodily integrity against the interest of the state in preserving life or the belief in the sanctity of human life; nor would it necessarily hold that the individual’s right to self-determination and privacy always outweighs society’s interest in the preservation of life. Furthermore, in our law a person who assists another to commit suicide may, depending on the circumstances of the particular case, be guilty of murder or culpable homicide ...

It is clear that the judge was not prepared to give full recognition to generally held modern medical views on patient autonomy. His ruling on this point was nevertheless not decisive as far as his ultimate finding in Clarke’s case was concerned.

The essence of the ruling in Clarke was that discontinuance of medical treatment in the circumstances of the case would not be unlawful. In brief, the reasoning of the court was as follows: The decision whether the discontinuance of the artificial nutritioning of the patient and his resultant death would be wrongful, depends on whether, judged by the boni mores of our society, it would be reasonable to discontinue such nutritioning. This decision relates to the quality of life that the patient still enjoys.

Advances in medical science and technology, the judge said, have made it possible for patients who suffered a cardiac arrest and cessation of breathing and who according to the ordinary manner of thinking would therefore have been regarded as dead, to be resuscitated. Inherent in resuscitation, however, is the real danger that, by the time the patient has been resuscitated, his brain may be all but destroyed, while the autonomic nervous system and brain stem may nevertheless be able to keep the body biologically alive but securing only a life at the level of a plant or less. “In such a situation the doctor or the patient’s family has to decide whether it would be justified or reasonable to institute or maintain life-sustaining procedures which could prolong the life of the patient.”

According to the judge, it can never be said, though, that the “external decision maker” has a right to impose death. In the present case the judge said that the applicant – the patient’s wife – intended to withhold nutrition from the patient. The court acknowledged that feeding ordinarily has a special symbolic significance, but in the present case the artificial feeding did not have any such symbolic significance at all because the patient was quite unaware of it and would be equally unaware of it if it was withheld.

The hastening of a person’s death is ordinarily not justified and is therefore wrongful even
when the person is terminally ill and suffering unbearable pain ... . This is, however, no absolute rule. It has come to be accepted that the doctor may give a terminally ill patient drugs with the object of reliving his pain, even if, to the doctor’s knowledge, the drugs will certainly shorten the patient’s life ...

The judge also referred to the instance of a patient with brain damage who is attached to a ventilator: he is unconscious, but the machine keeps his heart and lungs going mechanically. The doctor decides that there is no chance of recovery so he “pulls the plug”. “On the principles of our law,” the judge said, “the doctor would in each of the above examples be exempt from liability if, judged by the legal convictions of society, his conduct was reasonable.”

Why then would it not be reasonable for someone to simply kill the patient by suffocation? The distinction, Thirion J said, “is to be found in society’s sense of propriety – its belief that things should happen according to their natural disposition or order”. The doctor who, while following the precepts and ethics of his profession, prescribes a drug in a quantity merely sufficient to relieve the pain of his patient, is one who “acts within the legitimate context and sphere of his professional relationship with his patient”. Consequently, society adjudges his conduct justified in accordance with its criterion of reasonableness, and therefore not wrongful. (See 6.2.2 on the so-called “double effect” of pain medication.)

The judge was further of the opinion

... that in determining legal liability for terminating a patient’s life there is [no] justification for drawing a distinction between an omission to institute artificial life-sustaining procedures and the discontinuance of such procedures once they have been instituted.

He also did not think that there is any virtue in classifying the discontinuance of such procedures as an omissio.

The court was, therefore, of the view that, judged by society’s legal convictions, the feeding of the patient “does not serve the purpose of supporting human life as it is commonly known”, and accordingly his wife, if appointed as curatrix, would act reasonably and would be justified in discontinuing the artificial feeding, and would not be acting wrongfully if she were to do so.

According to the court, this conclusion made it unnecessary to deal with the argument advanced by her counsel that such discontinuance would not in law be the cause of the patient’s death if he were to die as a result thereof.

Lastly, it had to be decided whether the steps which Mrs Clarke proposed to take would be in the best interests of the patient. It had to be stressed that the court approaches those interests with a strong predilection in favour of the preservation of life, which however does not extend as far as requiring that life should be maintained at all costs, irrespective of its quality.

It is indeed difficult to appreciate a situation, save where the patient is suffering unbearable pain or is in a vegetative state, where it would be in his best interests not to exist at all. The patient in the present case has however passed beyond the point where he could be said to have an interest in the disposal of his body so I think the patient’s wishes as expressed when he was in good health should be given effect to.

In the event Mrs Clarke was appointed as curatrix to the person of her husband with the
power, *inter alia*, to withhold agreement to medical treatment of the patient and to authorise the discontinuance of any treatment.

It is to be noted that there is nothing in the judgment to suggest that it would be necessary in all cases of this kind for a *curator personae* to be appointed first. This was what the applicant in *Clarke’s case* had actually applied for. The **crux of the case is that discontinuance of treatment in casu would not have been wrongful.**

It is clear that even in the absence of formal appointment of a curatrix to articulate a decision to discontinue treatment, such a decision – whether taken by her and executed by the attending doctors or whether taken by the latter with her concurrence – would in the circumstances of the case not have been regarded as wrongful. In fact, **it would seem that a decision taken by the doctors on their own would have been regarded as reasonable and, therefore, lawful.** It is clear that in the event of a dispute, the doctors in a case of this kind may be called upon to justify their action, and thus circumspection and careful documentation of the investigations and circumstances are absolutely necessary.

When discussing *active euthanasia* we referred to administering medicines that may hasten death. Suppose, however, that a severely suffering patient’s condition is such that no treatment can prevent his death, but that he may live a little longer if he receives certain medication. We submit (as does Williams 291) that the doctor will not act unlawfully if he fails to administer these medicines.

### 6.2.3.3 A new approach to euthanasia

The South African Law Commission made no recommendation on *voluntary active euthanasia* in their *Report on Euthanasia and the Artificial Preservation of Life*, but proposed the following three options:

1. that the present legal position prohibiting *voluntary active euthanasia* be confirmed
2. that *voluntary active euthanasia* be regulated by legislation in terms of which a doctor be allowed to comply with a request of a terminally ill but mentally competent person, to end his or her unbearable pain
3. that *active euthanasia* be regulated by legislation in terms of which the final decision rests with a panel or committee applying specific criteria

The SA Law Commission also proposed that a *living will* should enjoy legal recognition to the extent that it requests passive termination of life.

According to Carstens P and Pearmain D *Foundational Principles of South African Medical Law* (2007) 206 it seems as if the underlying values and spirit of the Constitution support the acceptance of *voluntary active euthanasia* in South Africa. The constitutional rights on which they base this conclusion is the right to dignity (s 10), freedom of the person (bodily integrity – s 12), privacy (s 14), and access to emergency medical care (a 27). They argue that recognition of *voluntary active euthanasia* recognises the right to freedom of choice, which empowers people to take control of their own bodies. The choice should only be given to terminally ill patients who feel that, due to untreatable pain and/or loss of dignity and abilities, their lives are no longer of any value, and who repeatedly and actively seek help with suicide; who are mentally fully competent, and do not suffer from depression. They further argue that *voluntary active euthanasia* should be regulated and monitored to ensure the autonomy of competent terminally ill patients, while also guarding against abuse of the system.
World-wide euthanasia and assisted suicide remains a controversial subject. Jordaan L “The right to die with dignity: A consideration of the constitutional arguments (1)” 2009 THRHR 192 and “The right to die with dignity: A consideration of the constitutional arguments (2)” 2009 THRHR 1 argues that the complete criminal prohibition of voluntary active euthanasia is unconstitutional, and that exceptions should be allowed within the context of the doctor-patient relationship. She says that various forms of euthanasia, such as passive euthanasia in the case of incompetent patients, and even voluntary active euthanasia in the case of competent patients, already occur in practice in South Africa, and are allowed. She submits that regulating euthanasia is preferable to situations where “underground” activities in respect of euthanasia are denied, and a policy of conciliatory punishment or even non-prosecution is followed. She further submits that statutory regulation of clearly defined forms of euthanasia would best serve public interests.

Contrary to these views Malherbe R and Venter R “Die reg op lewe, die waarde van menslike lewe en die eutanasie-vraagstuk” 2011 TSAR 494 argue that the present legal position in South Africa, where active euthanasia and assisted suicide are criminal offences, is correct and should not be amended.

6.3 Interventions on healthy persons

Three kinds of procedures may occur here:

1. prophylactic measures applied to a healthy person
2. procedures involving a healthy person with the object of eventually curing an ailing person
3. operations performed with no curative objective

6.3.1 Prophylactic (preventive) measures

A medical procedure performed on the body of a healthy person to counter disease (prophylaxis) is not only a recognised practice in the modern world, but is most praiseworthy, and its lawfulness cannot be denied. Vaccination may serve as an example. Another example is malaria prophylaxis.

6.3.2 Curative objective

A procedure may be lawful where it is performed on the person of a healthy individual with a view to ultimately bringing about the restoration of the health of another person who is ailing. Examples of such procedures are the withdrawal of blood for the purpose of transfusion, which is a common practice nowadays, and removal of tissue such as skin, or of an organ, such as a kidney, for transplantation in or upon an injured or diseased person.

Taking blood samples and transfusing blood and blood products are partly governed by the National Health Act 61 of 2003 (55 and 56) and the regulations (GN R 401, GG 33188 of 14 May 2010) enacted in terms of that Act, as well as the Human Tissue Act 65 of 1983. The donation of human tissue and gametes is at present governed only by the Human Tissue Act 65 of 1983.

Please note that the National Health Act 61 of 2003 envisages repeal of the Human Tissue Act 65 of 1983. Chapter 8 of the National Health Act 61 of 2003 contains provisions with the import to regulate human blood, blood products, tissue and gametes. At the time of writing of this study guide the National Health Act 61 of 2003 is in the process of being phased in, and it will eventually replace the
Human Tissue Act in its entirety. The present position is that certain sections of the Human Tissue Act are still operational, while others have been replaced by provisions in the National Health Act 61 of 2003.

6.3.2.1 Anatomic donations by living persons

Because blood and blood products are partly governed by the National Health Act 61 of 2003 and partly by the Human Tissue Act 65 of 1983 while tissue and gametes are exclusively governed by the latter, we will at first briefly discuss the provisions of the National Health Act in respect of blood and blood products. Thereafter we will discuss the provisions in the Human Tissue Act in respect of blood, blood products, tissue and gametes.

Sections 55 and 56 of the National Health Act 61 of 2003 have been partly operative, at present only in respect of taking or transfusing blood or a blood product by someone other than a doctor. Regulations have been promulgated to regulate this situation in detail, and they appear in GN R 401, GG 33188 of 14 May 2010.

Section 55 of the National Health Act 61 of 2003 provides that blood and blood products may not be taken from the body of a living person without written consent by the person from whose body it is removed. Section 56 of the Act provides that blood and blood products removed from the body of a living person may only be used for dental or medical purposes, as may be prescribed. There are as yet no regulations defining these purposes.

The regulations of 14 May 2012 referred to above, contain the following provisions regulating removal of blood from the body of a living person by someone who is not a health care provider. A person who is not a health care provider may remove blood from another living person only if

- that person has received training at a health establishment that is specifically designed for removal of blood by persons including persons who are not health care providers (Reg 3(a))
- that person’s name has been recorded by the person in charge of the relevant health establishment in a register specifically designated for recording such persons’ names (Reg 3(b))
- the removal of blood shall only be by means of pricking a finger with designated equipment to obtain a small quantity of capillary blood sufficient for testing (Reg 4)

The training mentioned here is subject to certain provisions (s 5).

This covers the present provisions of the National Health Act 61 of 2003. The discussion which follows concerns blood, blood products, tissue and gametes, unless the context indicates otherwise.
resourceful detective work leads him to Dr Choppitov (HPCSA registration number: 666) and his sinister organisation, Tit for Tat Tissue Exchange, which we met in 5.2.2.1. Slowly Cluedo finds out what is going on. Cain Luvhengo supplements his supply of organs and gonads that he “harvests” from his victims with those that he gets from Dr Choppitov. These are, however, “worn” organs from his clients who received organ transplants. Information gained from Mma Ramotswe, the first female private detective in Botswana, further helps him complete the puzzle: Cain and his despicable cronies smuggle the organs across the northern border.

The one weak spot in Inspector Cluedo’s formidable crime fighting armour is his lack of knowledge of the Human Tissue Act 65 of 1983. Help Cluedo identify the relevant provisions of this Act while working through the following section.

The Human Tissue Act 65 of 1983 governs the removal of tissue, blood or gametes from the bodies of living persons for therapeutic and other uses. The Act defines “tissue” as “any human tissue, including any flesh, bone, organ, gland or body fluid, but excluding any blood or gamete”, and “any device or object implanted, before the death of any person”. “Gamete” is defined as “either of the two generative cells essential for human reproduction”, that is the male sperm and the female ovum (s 1).

The Act provides for the use of tissue, blood and gametes removed or withdrawn from the body of a living person for medical and dental purposes. This use includes the transplanting of tissue, the production of a therapeutic, diagnostic or prophylactic substance, the transfusing of blood, the production of a blood product and, in the case of a gamete, artificial insemination (s 19). (Obtaining gametes and artificial insemination will be discussed in 8.3.) Note that the Act makes no reference to purely scientific research and experimentation, and it is doubtful whether such activities could be described as “medical”.

Tissue, blood and gametes obtained from mentally ill persons may not be used for any of the said purposes; nor may tissue which is not replaceable by natural processes, or the gamete of a minor be used. A minor may, however, donate blood, skin and the like. Similarly, a gamete obtained from a habitual criminal may not be used. Tissue from the placenta, foetus and umbilical cord may not be used, except with ministerial consent (s 19).

Tissue intended for transplantation may be removed only in a hospital or other authorised institution (ie authorised by the Minister of Health). The medical superintendent of the hospital or institution must provide a written authorisation, and may not carry out the transplant himself (s 20). Note that these provisions do not apply to blood or gametes.

Removal of tissue, blood and gametes for any of the above-mentioned purposes may be effected only with the consent of the donor – in the case of a minor, the consent of his parents or guardians. This consent must be given in writing, except in the case of blood or tissue replaceable by natural processes. Moreover, in the case of donors of fourteen years or older who are mentally competent, no parental consent (or consent of a guardian) is required before replaceable tissue and blood may be removed. The minor may give his or her consent either in writing or orally. The Act also provides that tissue removed (with the necessary consent) for the sake of the health of the person concerned (eg bone from a leg amputated after a road accident) may be used for any of the above-mentioned purposes (s 18).
The use of a gonad for transplantation — if the result thereof could be procreation — is illegal, unless the Minister’s written consent thereto has been obtained in advance (s 21). The Act defines “gonad” as “the human organ which produces gametes”, that is a testicle in the case of a male and an ovary in the case of a female (s 1). (Note that artificial insemination is governed by regulations promulgated under the Act. Artificial insemination is defined in the Act in terms so wide as to include in vitro fertilisation. This subject is discussed by us in detail below.)

Only medical practitioners, dentists or persons acting under their supervision may remove and transplant tissue, withdraw blood, and administer blood or a blood product for any of the above-mentioned purposes (s 23). As we have seen above, other rules are applicable in respect of blood.

6.3.2.2 Removal of tissue from corpses

(Although our present topic concerns procedures performed on healthy persons, we will nevertheless discuss removal of tissue from dead bodies, which is also governed by the Human Tissue Act 65 of 1983.)

As we have intimated above, the acquisition of cadaver tissue is (from the juridical point of view) more problematical than tissue donation by live donors. The reason for this is that in civilised societies there is a deep-seated respect for the dead and compassion with the bereaved. (In our common law the violation of a dead body was a punishable offence and could constitute an iniuria to the next of kin.) Religious, humanitarian, aesthetic and hygienic considerations play a role here. Whilst the living donor is in a position to exercise control over the disposal of parts of his body, more extensive legal control is necessary in order to avoid the possible abuse of dead bodies. The donation of human bodies or of tissue from dead bodies is governed by chapter 1 of the Act. The provisions of this chapter are very extensive. It must be noted that the donation of eye tissue is particularly “favoured” by the Act.

(a) General conditions for legality

(i) The “donor” must be deceased

Section 7(2) of the Human Tissue Act 65 of 1983 provides that, for the purpose of removing tissue, the death of the person concerned must be established by two doctors, one of whom must have been practising for at least five years. These two doctors may not be members of the transplantation team. Eye tissue is specifically excluded from the afore-going provisions. In respect of eye tissue an ordinary death certificate will suffice. It would appear that the certification embodied in section 7(2) does not apply to the removal of tissue in the course of a medico-legal post mortem examination (which is discussed below). “Dead” may mean different things. For example, it may indicate absence of heart activity, or it may mean brain dead. Because the Act does not define “dead”, this requirement was the cause of heated debate in the past.

The National Health Act 61 of 2003 defines the concept dead in the definition section (s 1) as “brain dead”. (S 1 is already operative.) We submit that for the purposes of section 7(2) “brain dead” should be understood for the following reasons: the Human Tissue Act is in the process of being phased out, and will soon be replaced in its entirety by the National Health Act of 2003; the Human Tissue Act contains no definition of “dead”; organ donations will in future in any event be regulated by the National Health Act, and “brain dead” has for years been proposed as the criterion by experts.
As background we will briefly describe what is meant with brain death. It is generally accepted that, for the continuance of life in the human organism, the combined activity of the brain, heart and lungs is essential. Grave harm to or interference with the function of one of these organs has an almost immediate effect on the others. The most vulnerable of these organs is the brain. When the flow of blood to the brain is interrupted, unconsciousness follows within ten seconds and regular respiratory movements cease within a minute. According to doctors irreparable damage to the brain occurs after five minutes.

Today there is a variety of drugs and machines (eg the heart-lung machine) which can keep a person alive artificially in the sense that the heart-beat and blood circulation can be maintained. If the damage to the brain has reached the stage that the patient can be described as brain dead (cerebral death), one of two possibilities exist: treatment is ceased and “heart death” will occur within minutes, or treatment is continued and the heart may function for some time and then cease beating.

Brain death is irreversible damage to the brain and loss of brain function (including that of the brain stem), evidenced by total absence of response to stimuli (no reflex activity), total absence of spontaneous muscle activity, and a nil-reading (ie “still” or “iso-electric”) on the electroencephalograph (EEG) for a specific period. The pupils are dilated and fixed. In the absence of artificial ventilation or life-support measures cessation of cardio-pulmonary (heart-lung) functions will soon follow.

Accepting brain dead as the criterion means that doctors may switch off all machines when a patient is brain dead. It further means that an organ may be harvested from a body with a still beating heart, with a view to transplantation of the organ.

Electro-encephalogram

The advent of death as indicated on an electro-encephalogram
Who may receive donations?

Donation of the whole body, or of specific parts thereof, may be made to a hospital, a university and any other institution authorised thereto by the Minister. A specific doctor or dentist may also be indicated as a donee, or, naturally, in the case of tissue, any person requiring therapy for which the tissue can be used. If no donee is nominated or an institution or person other than those mentioned is nominated, the donation is of no force or effect (ss 3(1) and (2)).

It is not necessary for the donor to mention a specific institution by name. Thus, if he simply donates his body to "a hospital", the nearest hospital is deemed to be the donee (s 3(3)). If the donation has been made to a specific institution which is not within easy reach at the time of the donor’s death, the nearest institution in the appropriate category is regarded as the donee. If a doctor, dentist or patient has been nominated, however, and such person is not within easy reach, the donation likewise falls away (s 3(4)).

If the donor has made conflicting donations, effect is given to the donation made last. However, if the donor had first donated his whole body to one donee and thereafter donated specific tissue to another, the first donation becomes effective (s 3(5)).

Purposes of donation

A corpse or specific tissue may be donated to an institution, doctor or dentist for the purposes of medical or dental training, research, the advancement of medicine, dentistry or therapy (this includes the use of tissue in living persons), or for the production of a therapeutic, diagnostic or prophylactic substance. The tissue donated may be used only for these purposes. If the donee is a private individual, it may be donated for therapy. The purpose of a donation need not be expressly stated, but a donation is of no force or effect when made for any other purpose than those stated (s 4). Thus, if A donates his skull to his friend to be kept as a grisly memento mori, the donation will be void!

Consent

Consent to the removal of tissue from a dead body is a prerequisite, except in those cases (discussed below) where removal of tissue may take place in the course of medico-legal autopsies (see below). Consent may be given in one of the following ways:

1) By the deceased prior to his death. Such consent may be given in a will or in any document attested by two competent witnesses, who must be fourteen years of age or older. It may also be given by means of a statement made orally in the presence of at least two such witnesses (s 2). Any donation may be revoked by the donor prior to his death (s 5). However, a relative of the donor obviously cannot revoke or veto a donation made by the deceased.

2) By the spouse, any major child, any parent, guardian or any major brother or sister of the deceased, after his death. Such consent can be given only if the deceased has not (prior to his death) forbidden it (s 2(2)). The Act does not provide for revocation of such a donation, and it is submitted that such a donation is incapable of being revoked. Nor, it is submitted, can one relative veto a donation made by another.

3) If none of the persons mentioned in the preceding paragraph (ie the spouse, etc) can be traced, the Director-General of National Health (or someone authorised by him) may, instead of such persons, donate specific tissue for the purposes of the Act (s 2(2)). There are two conditions for the validity of such a donation: the deceased must not – prior to his death – have given a
contrary instruction; and the Director-General (or person authorised by him) must be satisfied that all reasonable steps have been taken to trace the person referred to in the preceding paragraph (s 2). The question arises whether the official concerned may make such a donation if the identity of the deceased is unknown. In our opinion this question must be answered in the negative. It is difficult to see how the official can be satisfied that all reasonable steps have been taken to trace the relatives if the deceased is unidentifiable. Further it is to be noted that the Act clearly does not visualise revocation of a donation by the official.

(v) Official authorisation

An act of official authorisation is necessary for the lawful removal of tissue from a corpse. This must be obtained upon request by a medical practitioner or dentist from any one of the following officials:

1. the magistrate in whose district the deceased died or where the body of the deceased is present (or another magistrate authorised by him)
2. the medical practitioner in charge of a hospital or authorised institution in which the deceased died, or of a mortuary where his body is kept
3. any other medical practitioner employed at such hospital, institution or mortuary who has been so authorised by the medical practitioner in charge (s 14(1))

The authorising official must be satisfied that the body or tissue was in fact donated, and that the body is no longer required for an official post mortem examination. He must also be satisfied that the removal of tissue is necessary for any of the purposes mentioned above (s 14(2)). The authorisation must be in writing, on the prescribed form. No official authorisation is necessary in the case of the removal of eye tissue (s 7(3)).

(vi) Removal of tissue under medical supervision only

The removal of tissue from a dead body for the purposes of the Act (ie for medical training, research, the advancement of science, therapy, etc) may be done only by, or under the supervision of, a medical practitioner or dentist. Obviously the tissue must be removed before the body is buried (s 14(2)(a)).

(vii) Gonads excluded

The transplanting of a gonad removed from a dead body which may result in procreation is prohibited in absolute terms (s 16).

(viii) Body not required for post mortem examination

Official authorisation may not be given unless the magistrate or medical practitioner is satisfied that the body is no longer required for the purposes of an examination in terms of specified statutes (s 14(2)). These are:

1. section 3 of the Inquests Act 58 of 1959 (post mortem examination where the deceased apparently died from other than natural causes)
2. section 46 of the Health Act 63 of 1977 (post mortem examination to establish the possible presence of an infectious disease)
3. section 15 (read with sections 16, 17 and 18) of the Births and Deaths Registration Act 15 of
1992 (*post mortem* examination where the deceased is apparently a still-born child but there is
doubt whether he is in fact still-born, or where the deceased was not treated by a medical
practitioner during his last illness, or where the deceased was so treated, and a medical
practitioner was unable to issue a death certificate)

(4) section 34 of the Occupational Diseases in Mines and Works Act 78 of 1973 (*post mortem*
examination of former mine and industrial workers)

Note that, in regard to examinations in terms of the Inquests Act, an exception is made: where the
district surgeon or pathologist of the area concerned certifies that, in his opinion, the removal of any
specified tissue will in no way affect the outcome of the examination, he may consent to such
removal (s 14(3)). The rationale of this exception is that the bodies of healthy young persons who
have died as a result of a criminal attack or from accidental causes are an excellent potential source
of tissue for transplantation. Moreover, it will frequently happen that where the victim of an assault
or accident is brought to a hospital in a state of near death, it is already unmistakably clear what the
cause of death will be.

If an organ or tissue were to be removed immediately after the death of such a victim, this would not
affect the outcome of the *post mortem* examination, which may take place only days later. Take the
example where a patient is brought to a casualty ward with a fatal stab-wound to the aorta. There
would be no objection to the removal of his corneas after his death but before the *post mortem*
examination.

Special provision is therefore made in the Act for the granting of official authorisation for the removal
of any specific tissue in medico-legal *post mortem* cases, provided that the doctor who is to conduct
the examination (or cause the examination to be conducted) certifies that:

(1) he is satisfied that the removal of the tissue will in no way affect the outcome of the examination
(2) he has no objection to the removal of such tissue (s 14(3))

It should be noted that these provisions do not nullify the consent requirements. Accordingly, the
body or tissue must have been duly donated for transplantation purposes, either by the deceased, a
relative, or, in the circumstances described above by the district surgeon. However, the Act contains
special provisions relating to the removal of tissue or organs during medico-legal *post mortem*
examinations without prior consent or official authorisation, which will now be discussed.

(b) **Removal of tissue during post mortem examination**

Because of the huge shortage of tissue and particularly organs for purposes of transplantation, and
the strict general requirements regarding consent, special provision has been made for the removal of
tissue (as prescribed by regulation) from a dead body on which a district surgeon or other doctor
performs a *post mortem* examination under the Inquests Act 58 of 1959 for donation to an
authorised institution.

The provisions relating to consent and official authorisation do not apply. However, no such removal
may be carried out if the medical practitioner involved

(1) is not satisfied that the removal of tissue will in no way affect the outcome of the *post mortem*
examination

(2) at the time of the examination, has reason to believe that the body or tissue has been donated,
or that the removal would be, contrary to any direction given by the deceased before his death.
These provisions are to be found in section 9 of the Human Tissue Act 65 of 1983. The ambit of the section was broadened in 1989 in order to include diagnostic (“hospital”) post mortem examinations.

It is clear that a body donated by a deceased or by any other competent person does not fall within the ambit of this section. It is also clear that any person who objects to routine removal of tissue from his body in the event of an unnatural death must “veto” such removal during his lifetime. However, the section does not create any legal machinery for the recording or registration of such “veto”.

In the past the Minister approved inter alia the following types of tissue or organs for removal: kidneys, bone tissue, tendon, cartilage, skin, heart valve, eyes, dura mater, liver, aorta, heart, and auricle.

Regulations concerning the requirements with which institutions must comply in respect of bodies and tissue were published by the Minister.

(c) Removal of tissue from bodies of deceased destitutes

A body surrendered to an institution in terms of a formal order issued by the inspector of anatomy in terms of section 12 of the Human Tissue Act 65 of 1983 may be used by such institution, in accordance with the regulations, for any of the statutory purposes such as medical training, research, transplantation, etc. It would appear that the provisions of the Act relating to consent and official authorisation do not apply to such use.

(d) Provisions designed to facilitate tissue acquisition

The Act contains a number of provisions which are designed to facilitate the donation and acquisition of human tissue. Thus the authorising official is empowered to act upon a will if, on the face of it, it appears to be legally valid, irrespective of the fact that the will has not yet been lodged or accepted by the Master of the Supreme Court (s 14(4)). As mentioned above, it is not a requirement for the lawfulness of an anatomical donation that the person making the donation must expressly specify the purpose of the donation. The Act further contains directions regarding conflicting donations. Provision is also made for the nearest hospital to become the donee if the hospital mentioned by the donor is not within easy reach.

(e) Time limit for removal of tissue

Except where the entire body is donated, the donee of tissue has 24 hours following the death of the donor within which he may remove the tissue so donated. After 24 hours have elapsed, whether or not the donee has removed the tissue, the body may be claimed by the relatives of the deceased, or by the person or persons otherwise entitled thereto, with a view to burial or cremation of the remains (s 7(1)).

Proper registers must be kept in respect of anatomical donations (see the regulations contained in GN R2876 of 29 December 1989 GG12234).

(f) General considerations relating to both deceased and living donors

(i) Rights concerning donated tissue

The person to whom a body or tissue is donated or who acquires tissue in terms of the Act, is vested
with exclusive rights over such body or tissue upon delivery of such body or tissue to him by means of use or otherwise, subject to the prohibition of the sale of tissue (s 36). This provision is especially designed to eliminate the possibility of the relative of a deceased donor and the relatives of a deceased recipient becoming involved in a distasteful conflict over the remains of the donor.

(ii) Sale of tissue prohibited

No person or body except an authorised institution (or in the case of tissue or gametes being imported, the importer) may receive payment in respect of the import, acquisition or supply of tissue or gametes for any of the purposes sanctioned by the Act. The same prohibition applies to blood or blood products, in respect of which only prescribed institutions are exempted. Authorised or prescribed institutions are specifically excluded from the prohibition to enable institutions such as tissue banks (which must incur costs when acquiring and preserving tissue) to be remunerated.

The prohibition on the sale of tissue does not, of course, prevent a medical practitioner from receiving remuneration for any professional service rendered by him to any person.

Note that the unlawful sale of human tissue is a criminal offence. If payment has been made for tissue, gametes or blood in contravention of the Act, the person who made such payment is entitled to a refund (s 28).

(iii) Genetic manipulation

Genetic manipulation of gametes or zygotes outside the human body is absolutely prohibited by the Act (s 39A). A zygote is the cell resulting from the fusion of two gametes; thus the fertilised ovum. (In our opinion section 39A prohibits human cloning. See our discussion on cloning below in 7.6.4.3.)

(iv) Secrecy

The Human Tissue Act contains a prohibition against the publication to any other person of any fact whereby the identity of the donor of the body of a deceased person or of any tissue thereof, or the donor of tissue removed from the body of a living person, may be established, without consent thereto in writing by the deceased prior to his death or by the living donor, or after the death of the person whose body tissue has been donated by one of the specified relatives who may consent, or by the district surgeon who donated the tissue. The Act contains a similar prohibition regarding the recipient. Such disclosure is unlawful, unless the recipient has consented thereto in writing. If the recipient has died without giving consent or without having indicated that he would not be prepared to give such consent, consent may be given by one of the following persons: a spouse or a major child or a parent or a major brother or a major sister of the recipient (s 33). Note that unlawful disclosure constitutes a punishable offence.

(v) Exclusion of civil and criminal liability

The Act exempts from civil and criminal liability a doctor who, for any of the purposes stated in the Act has, in good faith, removed any tissue from a dead body or from a living donor, in the event of any donation subsequently being found to be legally invalid. The same protection is afforded to a magistrate or medical practitioner who has authorised the removal of tissue (s 35).
(vi) Importing and exporting of tissue

The Act strictly controls the importing and exporting of tissue, dead human bodies, blood and gametes by means of a permit which has to be signed by the Director-General of Health (s 25). If tissue is imported contrary to the provisions of the Act, it must either be destroyed or removed from the Republic at the expense of the importer, or else it is forfeited to the State (in which event it may be destroyed or dealt with in such a manner as the Director-General may deem fit (s 26)). Contravention of these provisions constitutes a criminal offence.

(g) Offences

The Act creates a number of criminal offences which are punishable by a fine of R2 000 or imprisonment for a period not exceeding one year (or both). Amongst the offences are the following:

(1) acquiring, using or supplying the body of a deceased person, or tissue, blood or a gamete from a living person, in any manner or for any purpose other than is permitted by the Act
(2) using a gonad in the body of a living person contrary to the provisions of the Act
(3) removing tissue from the body of a living person, or using or transplanting tissue thus removed, by a person who is not a medical practitioner or a dentist
(4) disclosing the identity of a donor or recipient of tissue, otherwise than in accordance with the Act
(5) contravening a provision or condition relating to the importing or exporting of tissue, blood, a blood product or a gamete (s 34)

(h) Diagnostic post mortem examinations

In terms of section 8 of the Act, a post mortem examination of the body of a deceased person may be conducted before burial if the deceased gave consent thereto prior to his death, or if the autopsy is necessary to determine more precisely the cause of death, or for a specific scientific purpose. These provisions clearly indicate that consent by the deceased before his death is not an absolute requirement. All that must be established is that the autopsy is in fact necessary for the purpose stated. The Act contains no indication that the deceased’s relatives have to be consulted or that they have any right to veto an autopsy.

The provisions of section 14 relating to official authorisation (discussed above) also apply to post mortem examinations under section 8, except that the authorising official need not, of course, be satisfied that the deceased’s body has been donated for scientific or therapeutic purposes.

Where a (living) person consents to a post mortem examination of his body, this consent must be obtained in the same manner as if he were donating his body for scientific or therapeutic purposes.

Note that a post mortem examination may be performed only by a medical practitioner personally (see s 8, read with s 14(1)(b)).

ACTIVITIES

1. Explain the difference, if any, between active euthanasia and passive euthanasia.
2. Explain whether death due to the so-called “double effect” of analgesic substances administered during palliative treatment should be regarded as lawful or unlawful.
3. How is it going with your detective work? Do you have a solution for detective Konanani Cluedo (6.3.2.1)?

4. Answer the following multiple-choice question: Which one of the following options is correct?

In *Clarke v Hurst NO* 1992 (4) SA 630 (D) the court held that ...

(1) it would not in law be the cause of Dr Clarke’s death if Dr Clarke’s curatrix were to discontinue the artificial feeding.
(2) a medical practitioner cannot decide to discontinue the artificial feeding unless he/she has been appointed as the patient’s curator.
(3) the discontinuance of the artificial feeding would not be unlawful since it did not serve the purpose of supporting human life as it is commonly understood.
(4) it is not unlawful to withhold artificial life-sustaining procedures from the start, but it would be unlawful to discontinue such measures once instituted.
(5) the discontinuance of the artificial feeding would not be unlawful, since Dr Clarke was already brain dead.

FEEDBACK

1. “Active” euthanasia refers to an act of intentional mercy-killing which still constitutes murder in South African law. “Passive” euthanasia, on the other hand, refers to a situation where a very sick and sometimes aged person is virtually dying already and where the doctor and relatives of the patient agree “to stand back” and let nature run its course. Ethical, religious and philosophical considerations play a role in deciding on the legality of passive euthanasia. The benchmark case in South Africa is *Clarke*, supporting the view that medical treatment in extreme cases where the patient is in fact already dying, may be ceased.

2. The objective with which the drug is administered plays an important role here. Double effect is discussed under interventions where the objective is to relieve pain or to anaesthetise. Cases where such substances are administered in order to relieve pain are different from euthanasia, where the objective is to hasten the patient’s death. The first is lawful and the second unlawful.

3. Keep in mind that Choppitov gets his organs from living donors, while Cain gets his from murder victims. Also keep in mind the information which he obtained from a reliable source, as well as that which Mma Ramotswe gave him.

4. The correct answer is (3).

(1) It was not necessary for the court to deal with this argument as it based its decision on the finding that the conduct would not be unlawful/wrongful. Remember always to note the particular element of liability concerned.
(2) The court held that discontinuance of artificial feeding in the circumstances of the case would not be unlawful. The court did not require that a curator be appointed.
(3) The court was of the view that, judged by society’s legal convictions, the feeding of the patient “does not serve the purpose of supporting human life as it is commonly known”, and accordingly his wife, if appointed as curatrix, would act reasonably and would be justified in discontinuing the artificial feeding, and would not be acting wrongfully if she were to do so.
(4) The court was of the opinion that there is no justification for drawing such a distinction.
(5) Note that Dr Clarke was not brain dead, but was in a persistent vegetative state.

**GLOSSARY**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>active euthanasia</td>
<td>The expression “active euthanasia” is used to refer to the situation where someone commits an intentional act to end the life of a person suffering from an incurable disease, with the objective of relieving the person’s suffering.</td>
</tr>
<tr>
<td>assisted suicide</td>
<td>When someone commits suicide with another’s help, e.g., family member, friend or doctor. The final act is committed by the suffering person.</td>
</tr>
<tr>
<td>brain death</td>
<td>Irreversible damage to the brain and loss of brain function (including that of the brain stem), evidenced by total absence of response to stimuli (no reflex activity), total absence of spontaneous muscle activity, and a nil-reading (i.e., “still” or “iso-electric”) on the electro-encephalograph (EEG) for a specific period. The pupils are dilated and fixed. In the absence of artificial ventilation or life-support measures cessation of cardiopulmonary (heart-lung) functions will soon follow.</td>
</tr>
<tr>
<td>cerebral anoxia</td>
<td>Lack of oxygen on the brain.</td>
</tr>
<tr>
<td>cerebral cortex</td>
<td>Convoluted external layer of grey matter covering each of the cerebral hemispheres; makes up approximately 40% of the brain mass. It is responsible for integrating many of the higher functions, such as voluntary activity, conceptualisation, perception and sensation; directly responsible for consciousness; plays an essential role in memory, mental ability, and intellect; is linked directly or indirectly with all body parts.</td>
</tr>
<tr>
<td>contra bonos mores</td>
<td>Literally: “against the good morals”. Freely translated: “contrary to the legal convictions of the community”. Note that it is not contra boni mores” but “contra bonos mores”. Good morals are indeed boni mores, but here the word bonos is in another case, namely the accusative case, and therefore it is bonos. Pronunciation: “CON-tra BOW-nôs MOW-rays”.</td>
</tr>
<tr>
<td>curator ad litem</td>
<td>Curator appointed to handle the court proceedings of someone else. Pronunciation: “kew-RAH-tor UT LEE-têm”.</td>
</tr>
<tr>
<td>curator personae</td>
<td>Curator appointed to handle personal needs of someone else. Pronunciation: “kew-RAH-tor pêr-SOH-nigh”.</td>
</tr>
<tr>
<td>doli incapax</td>
<td>Not criminally responsible. Pronunciation: “DOW-lee IN-kah-pux”.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
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<td>-------------------------------</td>
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</tr>
<tr>
<td><strong>“double effect”</strong></td>
<td>Dual effect of certain substances used in palliative treatment of terminally ill patients; in addition to strong pain-killing (narcotic or analgesic) effect, it inevitably leads to death.</td>
</tr>
<tr>
<td><strong>dura mater</strong></td>
<td>Outer and strongest of the three membranes covering brain and spinal cord. Pronunciation: “DEW-rah MA-tër”.</td>
</tr>
<tr>
<td><strong>gamete</strong></td>
<td>Any one of the two sex cells necessary for human procreation, ie the male sperm and the female ovum.</td>
</tr>
<tr>
<td><strong>gonad</strong></td>
<td>Human organ that produces gametes, ie a male testicle or female ovary.</td>
</tr>
<tr>
<td><strong>inter alia</strong></td>
<td>Amongst others.</td>
</tr>
<tr>
<td><strong>involuntary active euthanasia</strong></td>
<td>Hastening the patient’s death without considering his wishes, or even against his express wishes, irrespective of whether the patient is able to give consent. The motive is always to end suffering.</td>
</tr>
<tr>
<td><strong>living will</strong></td>
<td>Written instruction made beforehand, stating that should the writer ever suffer from an incurable disease, or an injury that cannot be treated successfully, all life-support treatment must be ceased so that the person may die naturally. The document should preferably contain the statement that the compiler thereof is of sound mind. It should be done in the presence of two witnesses, who have to undersign in the presence of the compiler and each other.</td>
</tr>
<tr>
<td><strong>memento mori</strong></td>
<td>Literally: “Remember you have to die”. Pronunciation: “meh-MEN-toe MOH-ree”.</td>
</tr>
<tr>
<td><strong>morphine</strong></td>
<td>Strong analgesic (painkiller) and drug (numbs feeling). Used mainly to relieve strong and continuous pain. Brings a feeling of euphoria (optimism, happiness, wellbeing); user rapidly develops tolerance, so that higher doses are needed. May lead to addiction.</td>
</tr>
<tr>
<td><strong>palliative</strong></td>
<td>That relieves pain without healing the underlying disease. Hospice care is a good example of palliative care.</td>
</tr>
<tr>
<td><strong>passive euthanasia</strong></td>
<td>With the objective to be merciful, life-sustaining medication or treatment is ceased or withheld. A person who applies passive euthanasia refrains from preventing the death of a person from natural causes. It is usually understood that euthanasia is performed only with the object of relieving pain, and where the perception is that death will be more merciful than living. Passive euthanasia is thus effected by an omission (contrary to active euthanasia). Death thus occurs through the underlying disease of the patient.</td>
</tr>
<tr>
<td><strong>pentothal</strong></td>
<td>Substance administered intravenously; used to induce general anaesthesia. Central nerve suppressant; one of a group of medicines known as barbiturates.</td>
</tr>
<tr>
<td><strong>persistent vegetative state</strong></td>
<td>A neurological condition where the subject retains the capacity to maintain the vegetative part of neurological function but has no cognitive function. In such a state the body is functioning entirely in terms of its internal controls. It maintains digestive activity, the reflex activity of muscles and nerves for low-level and primitive conditional responses to stimuli, blood circulation, respiration and certain other biological functions, but there is no behavioural evidence of either self-awareness or awareness of the surroundings in a learned manner. Patient has no pain or discomfort, since he has lost ability to experience such sensations; however, patient is still alive, and life-expectancy is uncertain.</td>
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<tr>
<td><strong>post mortem</strong></td>
<td>Medical procedure where a corpse is examined to determine the cause of death. Only performed where the cause of death is unnatural or unknown.</td>
</tr>
<tr>
<td><strong>prophylaxis</strong></td>
<td>Pre-emptive or preventative measure such as inoculation, medication for preventing malaria, fluoridation of drinking water to prevent caries.</td>
</tr>
<tr>
<td><strong>pulmonary embolus</strong></td>
<td>Obstruction of pulmonary artery or one of its branches by an embolus, normally a blood clot, transported in the blood stream from a large peripheral vein. Symptoms may vary considerably: heavy, difficult or rapid breathing, continuous coughing, pain, coughing up blood.</td>
</tr>
<tr>
<td><strong>quantum (of damages)</strong></td>
<td>Amount or degree (of the damages).</td>
</tr>
<tr>
<td><strong>tissue</strong></td>
<td>Any human tissue, including any flesh, bone, organ, gland, or body fluid, excluding any blood or gamete, and any device or object implanted by a doctor or dentist before the death into the body of such person.</td>
</tr>
<tr>
<td><strong>toxoplasmosis</strong></td>
<td>Disease transmitted from mammals and birds to humans through contaminated raw or half-cooked meat, vegetables or milk products; through contaminated soil (eg where a cat had evacuated), or through direct contact with cats in particular. If a pregnant woman is infected during pregnancy and transmits the parasite causing the contamination (<em>Toxoplasma gondii</em>) to the foetus, it may cause serious symptoms, even death. Infection of the foetus often causes damage to the central nervous system, resulting in physical or mental disability. Blindness and damage to the liver is also common.</td>
</tr>
<tr>
<td><strong>voluntary active euthanasia</strong></td>
<td>When euthanasia occurs with consent of, or on request of, patient.</td>
</tr>
</tbody>
</table>
Medical intervention without a curative objective or where a curative objective does not necessarily play a role

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7.7.4 Experimentation on embryos and foetuses

Activities
Feedback
Glossary

LEARNING OUTCOMES

When you have completed this study unit, you should be able to

- explain the legal principles – either created by common-law or statutory law – which apply to a number of medical interventions, such as contraception (prophylaxis) cosmetic operations, and castration
explain the general legal principles and ethical views in respect of scientific experimentation involving human subjects – something that has been part and parcel of the evolution of medical science through the ages – as well as very recent forms of medical innovation such as stem-cell research.

explain legal aspects pertaining to relatively recent developments in the field of human genetics, in particular genetic manipulation, the Human Genome Project, and the highly controversial issue of human cloning.

7.1 Introduction
Medical law also concerns actions of professionals in the medical field which do not have healing as objective. Where neither the healing of a person subjected to a procedure or measure, or of another person, is the objective, the legality of the intervention depends on the question whether the objective is legally approved, and if there is no direct statutory provision, whether the intervention is not against the *boni mores*. In study unit 4 we said that the agreement between doctor and patient normally entails that the doctor will diagnose and treat the patient’s ailment. However, where the patient does not approach the doctor with a view to healing, but for another legal medical intervention, the agreement will of course be different. Consider, for example, the nature of the agreement between a plastic surgeon and a patient who wants a breast augmentation.

7.2 Pointless operation
A completely pointless operation undertaken in the knowledge that it is unnecessary – which is not without precedent in the medical world – is without doubt unlawful. This is so regardless of whether the operation was done skilfully, the patient consented, or whatever the motive. A pointless operation is for example one where there was no medical indication, but another motive, such as monetary gain. It stands to reason that such intervention would not be in the patient’s best interests. The guidelines for ethical practice of the HPCSA provide that doctors should refrain from providing an unnecessary service, whether for financial gain or otherwise.

7.3 Cosmetic operation
Cosmetic operations with the consent of the patient cannot be regarded as unlawful, unless the operation constitutes a threat to the patient’s life or health. Cosmetic operations may of course also have a therapeutic objective, as where they are done to improve a harmful psychic state in a patient. An example would be where the victim of a road accident, assault or fire sustained serious disfiguring injuries of the face which may be improved by drastic cosmetic surgery.

7.4 Castration
*Castration* entails surgical, chemical or other treatment which causes a man to lose the functioning of his testicles. *Castration* was historically performed in many cultures for religious or social reasons. For example, in the olden days the losers of a battle were often castrated by the conquerors. In certain cultures men in specific administrative positions or who were in charge of palace households (the harem of women) were also castrated. *Castration* can also be used as
punishment, for example in the case of sex offenders. Transsexuals may also decide on castration, as can people wanting a sex change operation.

It is doubtful whether castration that does not have healing as objective could be regarded as lawful. It is a moot question whether it should be allowed in order to prevent a sex offender from committing further sex crimes if psychotherapy was fruitless. In view of the drastic effects of such operation on the body and mind of the castrated person it should be treated as aggravated assault, save for the cases mentioned above. Also keep in mind the provisions of the Human Tissue Act 56 of 1983 on removal of a gonad from a living person (6.3.2.1 above).

However, in some other countries there is statutory provision for voluntary castration, for example to destroy an abnormally strong sex drive.

Certain remarks by our Appellate Division in S v V 1972 (3) SA 611 (A) may be of importance here. The accused, a 20-year-old youth, was sentenced to death after being found guilty on five counts of rape and (inter alia) five lesser counts in connection with sexual offences. He applied to the Appellate Division for leave to appeal against his sentence and at the same time to submit new evidence, inter alia concerning the possibility of undergoing brain surgery in order to destroy or diminish his sexual urge. The Appellate Division, however, refused to grant the application to submit further evidence. Jansen JA stated as follows:

Assuming [the evidence] to establish the possibility of complete rehabilitation, a court would not be entitled to impose a shorter sentence of imprisonment than it would otherwise have done, merely because of a possibility which has not yet received general acceptance in the field of penology. Moreover, our criminal procedure does not provide a court with the means to enforce or control such drastic methods of rehabilitation. Even the consent of the applicant to such an operation does not remove the many legal, moral and practical difficulties involved. A court would certainly not, at this early stage of development in this particular field of surgery and psychiatry, bring pressure to bear upon an accused to undergo such operation, by way of, eg, suspending any sentence upon appropriate conditions. Moreover, in the case of the applicant, on the evidence as it stands, it has not been established that the appellant’s conduct is to be attributed primarily to an overpowering sexual drive; on the contrary, Dr F considered the appellant’s conduct to be largely involved with a desire to be revenged upon society and to humiliate women, and he was not prepared to concede that it flowed primarily from any physiological, sexual basis.

On general considerations, however, the death penalty was set aside by the majority of the judges and replaced with a long term of imprisonment. The considerations in regard to the proposed brain surgery would have applied equally if castration had been at issue.

There is a tragic footnote to the case of V: In 1987 he was released. During the first days of 1989 he raped two women, one of whom he stabbed with a knife and killed; his other victim shot and killed him with his own firearm.

In our view castration may be permissible in the following situations:

1) Where a child is born with the sexual organs of both sexes. Such a person is known as a hermaphrodite. In such a case the child’s parents may for example decide that the male organs be removed to allow the child to grow up as a female.

2) A so-called transsexual who has the sexual organs of a male but is psychologically oriented as a female, may wish to be surgically “converted” into a female. In such cases there may be a
therapeutic objective, seen from a psychological perspective. See our discussion of transsexualism and so-called “sex change” operations in 7.5 below.

(3) There may be a sound medical reason for castration, for example where a man is diagnosed with testicular cancer. In such a case the operation will, of course, be performed with a therapeutic objective.

Note that the surgical removal of the testicles must be distinguished from so-called “chemical castration”, in other words, the administration of a drug which inhibits both sexual performance and desire. The drug used is an anti-androgen (androgen is a hormone, such as testosterone, that is responsible for developing and maintaining secondary male sexual characteristics) which is used in female contraceptives, the treatment of prostate cancer and the treatment of acne. It also blocks the male hormone testosterone which is produced in the testicles. Its effect on the suppression of sexual desire is reversible once the administration of the drug is stopped.

In 2003 a Durban magistrate sentenced a convicted paedophile inter alia to chemical castration. The accused pleaded for the castration in mitigation of sentence. The prosecutor contended that castration would fail to treat the psychological roots of sexually deviant behaviour (Legalbrief News Diary 28 October 2003).

7.5 Sex change (transsexualism or intersexuality)

This operation concerns the fate of the so-called “transsexual” – a person who has a normal male physique but feels emotionally like a woman or who, vice versa, is physiologically a woman but feels emotionally like a man. Medical practitioners emphasise that the transsexual is different from the hermaphrodite – a person born with the sexual organs of both sexes – and from the homosexual who merely has a sexual orientation towards his or her own sex. According to doctors and psychologists, the transsexual is usually a deeply unhappy person whose condition gives rise to serious personal psychological problems. Apparently psychiatric treatment is of little assistance in surmounting these problems. Through surgery, however, the transsexual can be given at least the appearance of the sex with which he or she identifies him- or herself.

The success of a sex change depends on whether changes may be made in respect of the following:

(1) Chromosomes. A chromosome is a small body which appears in the nucleus of a cell at the time of cell division. Chromosomes contain the genes, or hereditary factors, and are constant in number. The normal number in man is 46, with 22 pairs of autosomes and 2 sex chromosomes. Male and female chromosomes as a rule are clearly distinguished. The male sex chromosomes are xx and the female’s xy. At present no change is possible in the chromosome composition.

(2) Gonads. These are the testicles in the man and ovaries in the woman. Gonads may be removed.

(3) Genitalia. These are the penis in the man and the vagina in the woman. Genitalia may be surgically removed. A pseudo-penis and a pseudo-vagina can be created surgically.

(4) Hormones: testosterone in the male and oestrogen in the female. Hormones may readily be changed.

(5) Psyche. Changing the psychological identification of the transsexual with the opposite sex is very difficult.
(6) **Attitude of society.** It is not too difficult to change the attitude of society in respect of a person's classification as male or female.

Some doctors feel that the term “sex change” is misleading because a person's sex is determined at conception and indicated by chromosomes. Since chromosome composition cannot be changed, it is averred that changing someone's sex is physically impossible.

Other medical experts are, however, of the opinion that sex is primarily a question of psychological orientation and not so much of physiological appearance. They apply a psychological criterion in order to determine sex. Whatever the case may be, it is apparently quite impossible to reverse the roles in respect of the procreative function through such operations, although the operation does enable the patient to adjust himself or herself physiologically to the other sex, which might resolve certain psychological problems.

In the past the lawfulness of sex change operations was hotly contended, but the situation was changed with enactment of the Alteration of Sex Description and Sex Status Act 49 of 2003.

In South Africa, following a decision in which a divorce order was granted to a “married” female transsexual (*Jonker v Jonker* 1970 (T), unreported, discussed by Strauss 236), section 7B was inserted in 1974 in the Births, Marriages and Deaths Registration Act 81 of 1963 allowing "converted" transsexuals to re-register as the opposite sex. Subsequently, in *W v W* 1976 (2) SA 308 (W), the court considered the marital status of a married transsexual, and ruled that the typical "sex change" operation did not result in a biological change of sex, and that a “marriage” entered into between the parties was null and void. In 1992 section 7B was removed from the statute book.

Since then there has been a marked change in societal attitude towards “sex change”, which is echoed in the Alteration of Sex Description and Sex Status Act 49 of 2003. This Act provides for a change of sex description in the birth register in the case of a person whose sexual characteristics have been altered by surgical or medical treatment or by evolvement through natural development resulting in gender reassignment (s 2(1)). According to section 1, “gender reassignment” means a process which is undertaken for the purpose of reassigning a person’s sex by changing physiological or other sexual characteristics, and includes any part of such a process. “Sexual characteristics” means primary sexual characteristics (the form of the genitalia at birth), or secondary sexual characteristics (the characteristics which develop throughout life and which are dependent upon the hormonal base of the individual person, or gender characteristics (s 1)). “Gender characteristics” is defined as “the ways in which a person expresses his or her social identity as a member of a particular sex by using style of dressing, the wearing of prostheses or other means” (s 1). This Act clearly acknowledges the concept of “sex change” and upholds the psychological criterion as the decisive factor.

Finally we want to point out that an operation performed on a person who possesses the sex organs of both sexes (the hermaphrodite) so as to enable the person to be more compatible with one sex is, in our opinion, lawful if the required consent is present (see our discussion of castration in **7.4**). Hermaphrodites will most probably fall within the definition of an “intersexed” person, who, in terms of section 1 of Act 49 of 2003, is a person whose congenital sexual differentiation is atypical, to whatever degree. This means that a hermaphrodite may also apply for the alteration of the sex description on his or her birth register.

The Constitutional Court judgment in *Minister of Home Affairs v Fourie (Doctors for Life and Others, Amici Curiae); Lesbian and Gay Equality Project and Others v Minister of Home Affairs* 2006 (1) SA
524 (CC), in which the constitutionality of same-sex union was upheld, has greatly diminished the importance of the legal recognition of the change of sex effected by a sex change operation in so far as it might have a bearing on the validity of a marriage. In the meantime “same-sex marriages” have also been recognised by statute with the enactment of the Civil Union Act 17 of 2006 in November 2006.

Although “sex-change” by an unmarried person with a view to relieving grave psychoneurotic problems is not regarded as contra bonos mores, other considerations may apply in the case of a married person. “Sex-change” by a married person could give rise to grave legal problems, especially if the other party is against the sex change. Sex change can affect the essence of a relationship between partners. And yet, in our opinion, it is not inconceivable that if such a case were to come before court, it might appear that actual psychotherapeutic considerations could also be decisive in the interests of children or potential children. In the absence of such exceptional circumstances, it might be argued that consent to an operation on a married person could be judged as conflicting with the boni mores. But that argument will without doubt be met with the counter-argument that each person has the right to self-determination (personal autonomy).

7.6 Developments in human genetics

7.6.1 Background

[7.6.1 serves to provide some background for the ensuing discussion, and need not be studied for examination purposes.]

Genetics is the study of heredity. The term “genetics” comes from the word “gene” which is the biological unit of heredity located on a particular chromosome. The chromosomes are small, more or less rod-shaped bodies which appear in the nucleus of a cell at the time of cell division. They contain the genes or hereditary factors. The genes determine the thousands of characteristics which living things inherit from their parents – such as hair colour, eye colour and height, to mention only a few. Humans normally have 23 pairs of chromosomes, thus a total of 46 chromosomes. All people inherit their chromosomes from their parents. One of each pair of chromosomes comes from the father, and one from the mother.

Chromosomes
Genetic information is stored in living cells in long chainlike molecules of deoxyribonucleic acid (DNA). DNA forms chromosomes that are part of cells of all living organisms. These DNA chains carry hereditary “coded” instructions that cells follow to make proteins, the prime molecules of life. DNA accordingly carries the hereditary information that an organism passes on to its offspring – it determines that a cat will produce a cat, not a dog.

For many years now it has been possible for doctors to pick up genetic information such as a genetic disorder in a foetus in utero by means of amniocentesis – examining the fluid in the uterus surrounding the foetus. In cases where a serious disorder is detected, the doctor may advise the parents to have the pregnancy terminated. (More on this in study unit 11.)

**7.6.2 Genome mapping and the Human Genome Project**

A genome is the total of the DNA in a specific organism, including the gene. DNA is the substance (nucleic acid) in the nucleus of a cell. It contains the genetic information. The word genome (chromosome system, hereditary factor complex) refers to the total set of hereditary factors of a person contained in his or her chromosomes. The haploid human genome (genetic information in a single gamete) consists of approximately three billion base-pair sequences.

Genome mapping entails “spelling out” the specific sequence of the molecular “letters” forming the genetic code, as fixed in the DNA. These “molecular letters” are the base pairs to which we have referred above. The genome therefore contains approximately three billion “letters”.

The Human Genome Project is an international project which numerous countries and organisations supported. It ended in 2003. The purpose of the Human Genome Project was the following:
to identify the 20,000–25,000 genes in the human DNA

to determine (chart) the sequence of the 3 billion chemical base pairs comprising human DNA

to store this information in data bases

to improve methods and instruments of data analysis

to make the technology available to the private sector

to identify and solve the ethical, legal and social problems in respect of this information

The primary aim of the Human Genome Project was thus to advance knowledge rather than to identify disease patterns and mutations. Its most important outcome will be to increase understanding of the ways in which genes interact with each other and with the environment to generate normal structure and functions. This information can now be used for further research.

The Human Genome Project has led to the discovery of some 1,800 disease-causing genes. Approximately 2,000 genetic tests for human conditions have become available. Many products resulting from the Human Genome Project and developed in the biotechnology industry are currently being tested in clinical trials.

7.6.3 Genetic counselling

The information obtained through research and projects such as the Human Genome Project can be used to limit the number of pathogenic genes (causing disease) in the population. With such information carriers (people carrying the defective gene, but who do not develop the disease associated with that gene) and people with genetic diseases may take informed decisions regarding procreation. The hereditary risks can sometimes be determined with precision. With hereditary diseases that only develop in later life, people with such a gene can take preparatory measures with a view to the onset of the disease.

Genetic testing and counselling of individual patients with genetic disorders or of couples who may in future have a baby with a severe genetic disorder, is already widely practised all over the world and accepted as beneficial. Genetic screening programmes performed in society at large can also play an important role in public healthcare. They can be costly, however, and may raise serious ethical issues if applied only to select groups or parts of a population. The factor of confidentiality of screening results also comes to the fore.

For a comprehensive discussion of the ethics involved in both individual genetic testing and genetic screening in general, see the MRC publication Guidelines on ethics for medical research Book 2 (2002) 15–37.

7.6.4 Genetic manipulation

7.6.4.1 Introduction

Advances in biology in the latter half of the twentieth century have enabled researchers working on genetic manipulation to develop and refine a number of micro-techniques to “cut”, “excise”, “insert” or “recombine” certain sequences of DNA, which means that they are now able to manipulate hereditary material, and therefore heredity itself, in ways never dreamt of before. With techniques of
cloning, for example, it is now possible to make identical copies, not only of cells, but also of individuals. (We shall return to this below in 7.6.4.3.) It is also possible to introduce new characteristics to the functioning of existing cells or organisms.

Genetic manipulation

Once scientists know how each human gene works and how it can malfunction, they can design sensitive diagnostic tests, find the genetic roots of diseases, customise medicines to each individual’s unique genetic make-up – and perhaps even replace defective genes with normal ones.

Research into gene therapy began late in the twentieth century. Gene therapy involves a process whereby corrective implants are used to treat a wide range of diseases, from hereditary illness to cancer and heart disease. So far human trials have been somewhat disappointing, but new developments occur at an inordinate speed. Early in 2000 a breakthrough was reported in combating a genetic disorder in the form of severe combined immunodeficiency in babies. Babies were given a normal copy of the defective gene responsible for the disease. Bone marrow transplantation, which is a risky procedure, is thus avoided.
Another development benefits infertile women. The genetic make-up of such a woman can be introduced into an ovum (egg) donated by a fertile woman, so that the resulting child will carry the infertile woman’s genes instead of the donor’s.

### 7.6.4.2 Gene therapy

**Gene therapy** entails the alteration of cells by genetic manipulation and the use of the altered cells to treat, prevent or cure an undesirable condition. Researchers are interested in the following possibilities: Substituting a healthy copy of a gene for a mutated disease-causing copy of the gene; introducing a new gene capable of fighting disease into the body of an afflicted person; and inactivating a mutated malfunctioning gene.

It goes without saying that curing patients with serious ailments by means of *gene therapy*, as described above, is deserving of praise and altogether lawful, as long as there is no unlawful experimentation with persons or human embryos.

Although *gene therapy* is practised today in a number of countries, it has not yet been assimilated into mainstream medical practice. It is still perceived to be different, both in its nature and possible consequences, from any treatment used hitherto in medical practice. *Gene therapy* is currently only being tested for the treatment of diseases for which no other cure is available.

According to the MRC *gene therapy* should be considered to be in the research stages and therefore subject to those ethical considerations that currently govern genetic and medical research.

For a detailed discussion of these ethical considerations, consult the publication of the MRC, *Guidelines on ethics for medical research* Book 2 (2002) 6–15.

### 7.6.4.3 Cloning

**Cloning** may be defined as the technique whereby a genetically identical duplicate of an organism is produced through genetic manipulation.

When an egg is fertilised by a sperm, a zygote is formed, and the zygote develops into an embryo. Sometimes an embryo splits into two. When this occurs two identical (monozygotic) twins develop. It can be stated that monozygotic twins are natural clones of each other, since they are genetically identical. It is possible to split embryos that have been created *in vitro* artificially by means of a technique called “embryo splitting”.

It is also possible to produce a clone by means of a technique called “somatic cell nuclear transfer” (SCNT), nuclear transplantation, or nuclear substitution. Normally fertilisation occurs when an egg cell is fused with a sperm. However, this technique involves the fusion of an egg cell with an ordinary somatic (body) cell. By far the greatest part of an individual’s DNA, the so-called chromosomal DNA, is contained in the nucleus of almost every cell in his or her body. (The rest is found in the mitochondria and is maternally inherited.) In *somatic cell nuclear transfer* the nuclei of the two cells are removed and the nucleus of the somatic cell is substituted for the nucleus of the egg cell. The product of the fusion is encouraged to develop through subjecting it to an electrical current. If the process is successful a clone is produced that is genetically identical to the person whose somatic cell was used for this purpose. The clone thus has the same chromosomal DNA as the entity from whom the somatic cell was derived.
The difference between reproductive cloning and therapeutic cloning relates to the different objects behind the cloning. In the case of reproductive cloning the object is the creation of a child (iow, reproduction). The idea is to transfer the successfully cloned embryo to a woman’s womb so as to enable her to give birth to a child in due course. In the case of therapeutic cloning the object is to use stem cells obtained from the cloned embryo as a source of cells that can be implanted into a person who suffers from some or other disease. The object can also be to use the cloned embryo for research.

Somatic Cell Nuclear Transfer (SCNT)

The National Health Act 61 of 2003 (s 57) distinguishes between reproductive cloning and therapeutic cloning. Reproductive cloning is defined as the manipulation of genetic material in order to achieve the reproduction of a human being. Nuclear transfer and embryo splitting are included within the definition (a 57(6)(b)). Section 57(1)(a) prohibits the manipulation of any genetic material, including genetic material of human gametes, zygotes or embryos for the purpose of the reproductive cloning of a human being. Section 57(1)(b) provides that no person may engage in any activity, including nuclear transfer or embryo splitting for the purpose of the reproductive cloning of a human being. Embryo splitting entails the splitting of an embryo in the early stages (2–8 cells) into individual cells.

The Act defines therapeutic cloning as the manipulation of genetic material from either adult, zygotic or embryonic cells in order to alter, for therapeutic purposes, the function of cells or tissues (s 57(6)(b)). The Act vests the Minister of Health with the authority to permit therapeutic cloning utilising adult or umbilical cord stem cells under such conditions as may be prescribed (s 57(2)).

Contravention of a provision of section 57 constitutes an offence. It is punishable with a fine or imprisonment for a period not exceeding five years or to both a fine and such imprisonment (s 57(5)).
7.7 Scientific experimentation and research

7.7.1 Introduction

[7.7.1 serves as an introduction only, and need not be studied for examination purposes.]

Humankind is constantly shifting the frontiers of knowledge. At the forefront are the researchers. Research is constantly being conducted in the field of human biology and medical science. The new insights deriving from research findings enable scientists to develop new methods of treatment. Over the last number of decades man’s understanding of genetics in particular has grown at an astounding pace. The Human Genome Project (which we discuss below) produced an enormous amount of knowledge about human genetic make-up. The advances made in our understanding of the human genome and the functioning of human genes have led to developments in biotechnology. The law is struggling to keep up with the regulation of research in the field and new scientific techniques flowing from such research. Scientific progress almost always precedes regulatory efforts. Our discussion of this fascinating topic will reflect this trend. Don’t be surprised if this study unit contains a considerable amount of scientific facts. While we may have a much better understanding of cloning, stem cells and the promise that research on embryos might hold, these developments pose a great challenge to legislatures and policy makers worldwide to attempt to come up with a suitable regulatory framework. Scientific progress brings with it some serious ethical conundrums, giving rise to some diverging views. There are no final answers to these problems. Further legislative or regulatory developments are to be expected. Welcome to an exciting grey area – the interface between law and ethics. Anybody who wishes to stay abreast of the debate surrounding human cloning, stem cell research and research with embryos must possess a basic knowledge and understanding of the state of science. Since the regulatory framework is still in its infancy, and further developments can be expected, we deemed it fit to rather equip you with a basic knowledge of the state of science so as to enable you to follow the debate.

7.7.2 Lawfulness of experimentation and the regulation thereof

At the outset we draw your attention once again to section 12(2)(a) of the Constitution, which enshrines the right of everyone not to be subjected to medical or scientific experiments without their informed consent (1.4 above). We have already touched on experimentation on the bodies of ailing persons (6.2.1 and 6.3.2.1).

There can be no doubt that scientific experimentation practised on healthy persons without the direct objective of curing an ailing person or of finding a cure for a particular disease is, within narrow limits, justifiable on the basis of consent. Consent to suffer a minor injury or a temporary slight impairment of health in order to put to the test sound scientific or psychological hypotheses (e.g., the effect of alcohol on a person) that may be of value to science may likewise not be viewed as contra bonos mores.

Reckless experimentation which is not directed at gaining scientific knowledge, on the other hand, is decidedly illegal, and this also applies to experimentation which may be of scientific value but which entails the likelihood of serious bodily harm or impairment of health.

Where the experiment does in fact take place with the object of curing ailing persons, a consideration in assessing the lawfulness of the operation is the availability of a patient suffering
from the disease for which the remedy is sought. Where such a patient is available for experimentation, it will be hard to justify experimentation on a healthy person. If the experiment can be carried out just as well on an animal, it is again clearly unjustifiable to carry it out on a human being.

The risk involved in the experiment must be in relation to the value which a positive result would have for humankind.

Section 11 and 71 of the National Health Act 61 of 2003 govern research on and experimentation with human subjects. Before a health establishment provides a health service for experimental or research purposes to any user, the health establishment must inform the user in the prescribed manner that the health service is for experimental or research purposes or part of an experimental or research project (s 11(1)). The provision of a health service for the experimental or research purposes must be authorised beforehand by

- the user
- the healthcare provider primarily responsible for the user’s treatment
- the head of the health establishment in question, and
- the relevant health research ethics committee or any other person to whom that authority has been delegated (a 11(2))

Section 71(1) stipulates that research or experimentation on a living person may only be conducted

(a) in the prescribed manner, and
(b) with the written consent of the person after he or she has been informed of the objects of the research or experimentation and any possible positive or negative consequences on his or her health.

Section 71(3) governs research or experimentation to be conducted on a minor for a non-therapeutic purpose. Paragraph (a) provides that such research or experimentation may only be conducted

(i) in such a manner and on such conditions as may be prescribed
(ii) with the consent of the Minister of Health
(iii) with the consent of the parent or guardian of the minor, and
(iv) if the minor is capable of understanding, the consent of the minor.

Paragraph (b) makes it clear that the Minister may not give consent in circumstances where

(i) the objects of the research or experimentation can also be achieved if it is conducted on an adult
(ii) the research or experimentation is not likely to significantly improve scientific understanding of the minor’s condition, disease or disorder to such an extent that it will result in significant benefit to the minor or other minors
(iii) the reasons for the consent to the research or experimentation by the parent or guardian and if applicable, the minor are contrary to public policy
(iv) the research or experimentation poses a significant risk to the health of the minor, or
(v) there is some risk to the health or wellbeing of the minor and the potential benefit of the research or experimentation does not significantly outweigh that risk.

In South Africa the South African Medical Research Council (MRC) is charged in terms of the
South African Medical Research Council Act 58 of 1991 with the duty of exercising proper control over the utilisation of human or animal material in experimentation relating to matters under the control of the MRC. A comprehensive set of guidelines was published by the MRC in its publication *Guidelines on ethics for medical research* (1st ed 1979; latest edition in a series of small volumes, 2000–2005).

In terms of section 14 of the Medicines and Related Substances Act 101 of 1965 no person may sell any medicine subject to registration in terms of a resolution of the Medicines Control Council, unless it is registered. In terms of section 15 formal application must be made for registration, and the Council may undertake an investigation or inquiry. The Council will evaluate the researcher’s protocol for clinical trials prior to its implementation. The application for registration must contain details of clinical studies. The formalities pertaining to applications for clinical trials are set out in GN R510, GG 7636 of 10 April 2003, Regulation 34.

### 7.7.3 Stem cell research

**Stem cells** are the basic cells that form all the cells in the body. They are unique in the sense that they are the only type of cells that can change their function; other cells are differentiated, which means that they have already developed into more specialised cells with a more specialised function, such as brain cells or muscle cells. **Stem cells** have the ability to replicate and develop into different cell types (there are nearly 220 cell types that make up the human body). **Stem cells** therefore bring forth the cells that gradually build up our bodies from a fertilised **ovum**. In adults, **stem cells** are responsible for producing **somatic cells** with a limited lifespan, such as epithelial skin cells and red blood cells. **Stem cells** have two characteristics that allow them to accomplish this: the ability to replicate and the ability to differentiate into different specialised cell types (such as liver cells, kidney cells, muscle cells, brain cells, etc).

**Stem cells** can be categorised according to their developmental stage and their ability to differentiate. A fertilised egg (zygote) is capable of producing an entire human being by way of continuous cell division. A fertilised egg is **totipotent** because it has the ability to differentiate into every type of cell of the adult organism and to produce an entire individual.

In the early stages of its development, prior to implantation in the uterine wall, an embryo is called a **blastocyst**. The **blastocyst** consists of an outer layer which develops into the placenta, and an inner cell mass which develops into the foetus. **Embryonic stem cells** are found in the inner cell mass of the blastocyst. **Embryonic stem cells** are **pluripotent**. This means that an **embryonic stem cell** – like a **totipotent stem cell** – has the capacity to differentiate into almost every cell type of the human body, but – unlike a **totipotent stem cell** – has lost the ability to develop into an entire new person.

During the early stages of foetal development, cells called **primordial germ cells** are found in the foetus’ **gonads**. These cells are the precursors of the foetus’ gametes and are also **pluripotent**.

Another category of **stem cells** is **multipotent stem cells** – **stem cells** that are to some extent already differentiated but still have the capacity to develop into a limited number of specialised cell types. It is thought that **adult stem cells** are **multipotent stem cells**. Let us use hematopoietic (blood forming) **stem cells** to illustrate what this means. Hematopoietic **stem cells** are **adult stem cells** that occur in bone marrow. Hematopoietic **stem cells** have the capacity to produce cells that make up two different types of tissue, namely blood and lymphatic tissue. **Adult stem cells** are not limited to adults, but are found in adults and children alike. Umbilical cord and placentas are sources thereof,
and the use of such stems cells are therefore much less controversial because it does not imply the destruction of a developing human life. Although stem cells obtained from adults (eg from bone marrow and brain tissue) can therefore also be used for research purposes, it is not yet clear, however, whether adult stem cells will prove as versatile as embryonic ones.

What are the potential benefits of stem cell research? Stem cell research can shed light on the basic genetic mechanisms underlying the process of development, for the very reason that they are able to develop into different types of cells. Scientists believe that stem cells could be used to cure diseases once regarded as incurable, such as Parkinson’s disease, Alzheimer’s and diabetes.

The most controversial issue of stem cell research is the sources from which the stem cells utilised for research are obtained. Embryonic stem cells are usually harvested from embryos that were created for the purposes of in vitro fertilisation but never used for that purpose. The primary source of primordial germ cells is aborted foetuses. There are widely diverging opinions on the use of embryos and foetuses for research purposes.

In some countries, legislation has been passed prohibiting the use of embryos and foetuses as sources of stem cells, but allowing the use of existing stem cell lines that have already been produced in laboratories.

There is much less opposition to the use of adult stem cells for the purposes of research, and few people would object to the application of bone marrow transplants that have been developed through research on adult stem cells. Some very promising research has been done on adult cells. This research shows that adult cells can be genetically altered to resemble embryonic stem cells. These cells are genetically manipulated to express genes and factors important for maintaining the defining properties of embryonic stem cells. Cells that have been manipulated in this way are known as induced pluripotent stem cells (iPSs). In the past it was thought that the process of cell differentiation is irreversible, but the development of iPSs has shown that differentiated cells can be reprogrammed to revert back to their undifferentiated state. Further research is needed to establish whether iPSs are safe to use in human therapies, but if it proves possible to produce useful pluripotent stem cells in this manner, stem cell research will undoubtedly become much less controversial.

What is the connection between cloning and stem cells? Non-reproductive or therapeutic cloning is considered by some as a technique that can be employed to obtain stem cells. However, stem cells can be obtained from many other sources. Stem cells harvested from cloned embryos have certain advantages when it comes to therapeutic application, since they have the same genetic make-up as the person whose somatic cell was used. If an embryo were to be cloned using one of your somatic cells, it would have the same genes as you do. If cells obtained from the cloned embryo were to be implanted in to your body, your body’s immune system would not recognise them as foreign invaders. Therapeutic cloning therefore holds huge potential if applied in gene therapy, since it is not accompanied by the same risk of rejection by the immune system as is associated with genetically different cells.

Currently, the National Health Act 61 of 2003 vests the Minister of Health with the authority to permit research on stem cells and zygotes which are not more than 14 days old. Written application must be made to the Minister, and the applicant must undertake to document the research for record purposes, and obtain consent from the donor of such stem cells or zygotes beforehand (s 57(4)).
7.7.4 Experimentation on embryos and foetuses

Since the development of *in vitro* fertilisation more than three decades ago, it has been possible to produce embryos outside the human body. (We will learn more about *in vitro* fertilisation in study unit 8.) More recently (in 1996), Dolly the celebrated sheep was cloned. This event captured man’s imagination as the cloning of a human being was suddenly a more realistic possibility. Stem cells (which we have just discussed) started to receive unprecedented interest in scientific circles. In the meantime the subject of stem cell research on human embryos unleashed a vehement debate internationally. Human cloning (which is discussed in 7.6.4.3), embryonic stem cell research and research on embryos are closely connected.

The object of research on human embryos can be either therapeutic or non-therapeutic. The object is therapeutic if the research is aimed at benefitting the embryo itself. The object is non-therapeutic if the research is not aimed at benefitting the embryo. Non-therapeutic research is more controversial than therapeutic research. Research on embryos played an important part in the development of technologies aimed at helping couples with reproductive problems. Huge potential lies hidden in further research on embryos. Apart from expanding our fundamental scientific knowledge, research on embryos may lead to the development of new reproductive and cloning techniques, and the therapeutic use of embryonic cells (especially embryonic stem cells). It may enable us to change the genetic constitution of an embryo (eg so as to exclude genetic disease). Research on embryos often has more than one objective and often leads to unexpected results. It may sometimes even be necessary to create embryos for the purpose of research, for instance where the development of a technique aimed at causing fertilisation of an egg cell is concerned. The production of embryos for research purposes is even more controversial than the practice of conducting research on existing embryos.

The regulations on the use of biological material, published in GN R177, GG35099 of 2 March 2012 contain a number of provisions pertaining to research on embryos. Regulation 7 stipulates that excess embryos obtained from *in vitro* fertilisation may be used to produce embryonic stem cell lines for the purpose of research, provided that the competent person obtains written informed consent from the embryo donor or cord blood donor.

Regulation 8 provides that research on primordial germ cells obtained from aborted foetuses may be carried out, provided that the competent person obtains prior written informed consent from the donor of the aborted foetus.

Regulation 9 provides that any competent person who wishes to utilise embryonic, adult, foetal, or umbilical cord stem cells for stem cell therapy must obtain written informed consent from the donor of such stem cells.

The fact of the matter is that a large number of unused and “unwanted” embryos are presently stored in freezers of fertility clinics. During *in vitro* fertilisation clinics routinely fuse more than one egg with sperm. Many of these are not used. Many foetuses are also discarded in abortion clinics. Some researchers have created embryos purely for research purposes or as sources of stem cells. Some scientists have even tried to create cloned human embryos for this purpose. (Cloning is discussed in 7.8.3.) Some of these activities are highly controversial. There are millions of people all over the world who regard fertilisation as the commencement of human life, and the destruction of an embryo or foetus is contrary to their religious beliefs. On the other hand many scientists argue that it is a fact that thousands of embryos and foetuses would in any event be thrown away, and that it would be far better to use these for purposes of research which may eventually result in medical breakthroughs that can benefit a countless number of ailing persons.
Apart from the regulations set out above, there are also ethical guidelines available to researchers. The South African Medical Research Council (MRC) has laid down basic ethical guidelines for research relating to reproductive biology (see its Guidelines on ethics for medical research: Book 2: reproductive biology and genetic research (2002)) such as the following:

- The pre-embryo should be treated with the utmost respect because it is a genetically unique, viable human entity.
- If pre-embryo transfer to the uterus is envisaged, special care should be taken to ensure the welfare of the potential foetus.
- The production of excess embryos for the sole purpose of research should be discouraged (par 2.2). (A pre-embryo is defined as the product of gamete union from the time of fertilisation to the appearance of the embryonic axis. The pre-embryonic stage is considered to last for 14 days.)

As far as *in vitro* fertilisation is concerned the MRC states that there is consensus that there is no intrinsic moral problem in respect of the use of this technique in cases where gametes from the husband and wife are used (par 2.3). Research to improve the efficacy of gamete intrafallopian transfer (GIFT) is ethically acceptable (par 2.4). This procedure entails that semen and ova are mixed *in vitro* and immediately transferred to the woman’s Fallopian tubes. Fertilisation thus happens in the Fallopian tubes and not in a test tube.
As far as embryo transfer is concerned, the MRC is of the opinion that *in vitro fertilisation* has a high failure rate, and that it is common to place three or four embryos at a time in the uterus. Transferring more than four embryos may occasionally lead to multiple pregnancies, and is therefore not recommended (par 2.9). Maintenance of embryos *in vitro* beyond the gestational age of two weeks is not ethically acceptable (par 2.14).

The MRC recommends that research methods into *artificial insemination, donor (AID)* should be limited to the essential, and that adequate consent should be obtained from all people involved in the donation or reception of gametes. Artificial insemination procedures should be performed in full compliance with the applicable regulations. Proper counselling and consent are required where donor sperm is used (par 2.7). The use of donor eggs remains controversial, but provided the donor receives no compensation, the MRC finds the use of donor eggs ethically acceptable. However, attempts to extend child-bearing beyond the menopause have many medical, familial and sociological disadvantages, and research in this field is usually ethically unacceptable (par 2.8).

Research into the selection of foetal sex may be inappropriate if it could result in a request for an abortion because the sex of the foetus is unacceptable to the parents. On the other hand gender selection may be beneficial in sex-linked genetic diseases, and may be justified under exceptional circumstances (par 2.16).

*Pre-embryo* manipulation and research may yield valuable medical information. It can, however, only be regarded as ethical if the embryos are not produced specifically for the purpose of research. In addition, the embryos should not be transferred to the uterus unless there is reasonable certainty that the manipulation carries no potential risks for the foetus (par 2.17).

The use of *recombinant technology* (*recombinant DNA technology*, where the sex chromosome of the organism is changed) in selecting foetal sex is currently regarded as not ethical (par 2.18).

### ACTIVITIES

1. This study unit is packed with interesting concepts and terms. Test your memory, and complete the crossword puzzle on pp 178–179. Try not to consult the glossary. Where an answer comprises more than one word, leave an open space between the words.
Across
3. ... cloning. Cloning with the object to use stem cells obtained from the cloned embryo as a source of cells that can be implanted into a person who suffers from some or other disease, or to use the cloned embryo for research.
4. ... stem cell. Hematopoietic stem cell is an example of this type of stem cell.
6. A laboratory technique whereby the eggs are removed from a woman’s ovaries and inseminated with sperm in a petri dish. (3 Words.)
8. Basic cells that form all the cells in the body. (2 Words.)
14. ... cloning. Cloning in order to achieve the production of a child.
17. Short for artificial fertilisation of a woman by using semen from a donor (not her husband).

Down
1. ... cell. Ordinary body cell; any cell other than a gamete.
2. A procedure whereby semen and ova are mixed in vitro and immediately placed in the woman’s Fallopian tubes. (3 Words.)
5. Pluripotent stem cell found in the foetus’ gonads during the early stages of foetal development. (3 Words.)
7. ... stem cell. Cell that has been altered through manipulation to a state where it has regained the ability to differentiate into different types of cells. (2 Words.)
9. Cloning technique whereby an embryo in the early stages (2–8 cells) is split into individual genetically identical cells. (2 Words.)
10. ... stem cell. Stem cell to be found in the inner cell mass of a blastocyst.
18. Alteration of cells by genetic manipulation and the use of the altered cells to treat, prevent or cure an undesirable condition.  

19. Short for artificial fertilisation of a woman by using her husband's semen.  

21. Adenine (A) and thymine (T), or guanine (G) and cytosine (C).  

23. Person whose congenital gender differentiation is a-typical, to whatever degree.  

25. The full set of hereditary factors contained in a person's chromosomes.  

26. ... stem cell. Stem cell that is already differentiated to some extent, but still has the ability to develop into a number of specialised cell types.  

29. Cloning technique whereby an egg is fused with a somatic cell.  

30. Short for South African Medical Research Council.  

31. Male sex hormone responsible for the appearance of secondary male sexual characteristics and sex drive.  

32. Creating a genetically identical copy or duplicate of a person (or other organism).  

33. Deoxyribonucleic acid.  

34. Usually a person who has at least one copy of a gene in his/her genetic make-up which causes a specific illness that may be transmitted to his/her offspring.  

36. Testicles in the man and ovaries in the woman.  

2. Name and briefly discuss the situations where castration ought to be lawful.  

3. Boris sings baritone. He is deeply unhappy. As a child he often paraded in his mother's high heels and sister's dresses. Puberty was a nightmare: his body turned hairy, his voice deepened – in short, he felt as if nature was playing a nasty trick on him, sending his metamorphosis in the wrong direction. He was frequently the object of ridicule, and he was progressively ostracised and isolated by his peers. Boris became more and more socially withdrawn. Every time he had to fill out an official form, it felt absurd to indicate his sex as "MALE". Boris is now in his late twenties. With his long hair and meticulously manicured nails one would never recognise him for being male. His behaviour and appearances are stereotypically feminine. As entrepreneur in the entertainment industry, Boris has already made a name for himself. However, he introduces himself as Doris, and his sister's children know him as "aunty Doris" with the big Adam's apple. But Boris still sings baritone. He desires to...
be formally acknowledged to be female. The last straw was when the census official asked him: “Sir, are you a female?” A psychiatrist diagnosed Boris with gender identity disorder, and advised him to consider a sex change operation. Boris first wants to consider all the implications very carefully. He consults you.

(a) Boris wants to know whether a sex change operation is a prerequisite for officially changing his sex description to “FEMALE”.
(b) Boris wants to have a daughter of his own. He knows that it will be impossible once he has had a sex change operation, since this would entail that he be castrated. He considers artificial fertilisation of a surrogate mother using his own sperm. Boris wants to ensure that he fathers a little girl, and wishes to know whether it would be possible to employ genetic manipulation to determine the sex of his offspring. Boris also wants to know whether it would be acceptable to produce a number of embryos for in vitro fertilisation, and to select a foetus of the female sex for implantation in the surrogate mother’s womb.

4. Answer the following multiple choice question:

Tsietsi is 10 years old. He suffers from leukaemia (blood cancer). A team of scientists wants to make use of a new substance to try and cure Tsietsi. The scientists have established that a certain gene in Tsietsi’s composition does not function properly. If this gene functions properly, it fights cancerous hematopoietic cells. The scientists claim that the substance they have developed can activate this gene, causing it to fight the cancerous cells. The scientists want to treat Tsietsi with this substance since he has not responded well to other available treatments, and no existing treatment offers a cure. There is a risk that the substance may also affect healthy stem cells and seriously prejudice the child’s immune system. The National Health Act inter alia governs research on children. Which one of the following statements is correct?

(1) The researchers need to obtain the relevant health research ethics committee’s authorisation before they may proceed to treat Tsietsi with the new substance.
(2) The Minister may consent if he is of the opinion that the potential benefit to the public outweighs the serious risks to the child.
(3) The researchers can succeed with their application for permission to proceed with the research without first having to furnish proof that the objects of the research can only be achieved if it is conducted on a child.
(4) Provided the Minister gives his consent, prior authorisation by the head of the health establishment is not required.

5. Why is stem cell research so controversial?
6. Are there any other pluripotent stem cells the use of which is less controversial than that of embryonic stem cells?
7. Explain what is meant by human “reproductive cloning” and “therapeutic cloning” and also explain whether it is lawful or unlawful to use human cells for cloning purposes.

FEEDBACK

1. See crossword puzzle answers on p 180.
2. See our discussion in 7.4 above. It is sufficient to mention the three instances (hermaphrodite, transsexual and medical reasons such as cancer) and to write a sentence or three about each.

3. (a) It is not a prerequisite. Study the definitions of “gender reassignment”, “sexual characteristics” and “gender characteristics” attentively. Boris can apply for the alteration of his sex description if his sexual characteristics have been altered “by evolvement through natural development resulting in gender reassignment”. “Gender reassignment” includes any part of the process of gender reassignment. The process may be aimed at changing physiological or other sexual characteristics. “Sexual characteristics” includes “gender characteristics”. “Gender characteristics” is defined as “the ways in which a person expresses his or her social identity as a member of a particular sex by using style of dressing, the wearing of prostheses or other means” (s 1).

   (b) The MRC opines that research into the selection of foetal sex may be inappropriate if it could result in a request for an abortion because the sex of the
foetus is unacceptable to the parents. It seems as if this ethical guideline refers to the foetus in utero, and not to the situation where the sex of the foetus is determined before implantation. However, the MRC unequivocally states that the use of recombinant technology (recombinant DNA technology, where the sex chromosome of the organism is changed) in selecting foetal sex is currently regarded as not ethical. This is the ethical position according to the MRC’s ethical guidelines. In study unit 8 you will learn what the legal position in terms of the regulations governing artificial fertilisation is.

4. The correct answer is (1). See 7.7.2.
   
   (1) Remember that section 11 of the National Health Act also applies to research on or experimentation with a child. Section 71 is not the only relevant provision.
   (2) The Minister may consent where some potential harm is attached to the experiment or research but the risk weighs significantly less than the benefit to society. However, section 71(3)(b)(iv) provides that the Minister may not consent if the research or experiment poses a significant threat to the child’s health.
   (3) The Minister may not consent if the objects of the research or experiment can also be achieved if it is conducted on an adult.
   (4) The requirements of section 11 and 71 apply cumulatively. See section 11(2).

5. The usefulness of stem cells depends on their ability to replicate, and in particular, their ability to differentiate. A fertilised egg is totipotent and can differentiate into any cell type, but also has the ability to produce an entire new organism. Embryonic stem cells are currently arguably still the most advantageous stem cells for use in research, since they can differentiate into every type of cell found in the human body. Embryonic stem cells are therefore pluripotent. Adult stem cells do not have the same potential to differentiate. They are multipotent and can differentiate into a limited number of cell types only. Embryonic stem cells are found in the inner cell mass of a blastocyst (an early embryo). In the process of harvesting embryonic stem cells, the embryo is destroyed. There are many who believe that it is unethical, immoral or against their religious beliefs to destroy (developing) human life for the purposes of research. Others point to the potential held by stem cell research for the advancement of medical science as justification for the destruction of these embryos. Primordial germ cells (the precursors of a foetus’ gametes) are found in the gonads of foetuses. Most of the primordial germ cells used in research are harvested from aborted foetuses. While some find the idea abhorrent, others believe that it is not wrong to use such cells, since the foetuses would in any event be destroyed if they are not used for research purposes.

6. Yes. First, there are existing stem cell lines that have already been created in laboratories, and second, induced pluripotent stem cells (iPSs) seem like a promising alternative, although further research needs to be done to establish their versatility and safety for human use.

7. See 7.6.4.3. Start by defining cloning. Briefly discuss the various techniques that can be used to clone an organism (you may even use an illustration). Also include the statutory definitions of these two forms of cloning, and explain the provisions of section 57. Remember to point out that contravention of the provisions of section 57 amounts to an offence.
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<th><strong>GLOSSARY</strong></th>
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progesterone  A female sex hormone. Together with oestrogen it is responsible for breast development and the cyclic changes in uterine mucosa (menstrual cycle). It is partly responsible for preparing the uterus for the fertilised ovum. Progesterone inhibits ovulation during pregnancy and plays an important role in preparing the breasts for lactation.

recombinant (DNA) technology  See genetic manipulation.

sexual characteristics  For the purposes of the Alteration of Sex Description and Sex Status Act 49 of 2003 – primary sexual characteristics (form of the genitalia at birth), secondary sexual characteristics (which develop throughout life and depend on the hormonal basis of each individual), or gender characteristics.

somatic cell  Any cell other than a gamete. Also called a body cell.

somatic cell nuclear transfer  Cloning technique whereby an egg is fused with a somatic cell. In somatic cell nuclear transfer the nuclei of the two cells are removed and the nucleus of the somatic cell is substituted for the nucleus of the egg cell. The product of the fusion is encouraged to develop through subjecting it to an electrical current. If the process is successful a clone is produced that is genetically identical to the person whose somatic cell was used for this purpose. The clone thus has the same chromosomal DNA as the entity from whom the somatic cell was derived.

stem cells  The basic cells from which all the cells in the body are formed; can multiply indefinitely, and develop into any type of tissue.

testosterone  Male sex hormone. At puberty, testosterone initiates the maturation of the male reproductive organs and the appearance of secondary male sexual characteristics and sex drive. Testosterone is also essential for normal sperm production and maintains the reproductive organs of adult males in their mature functional state.

totipotent (stem cell)  Cell that has the ability to differentiate into every type of cell of the adult organism and to produce an entire individual. Fertilised egg cell is a totipotent stem cell.

transsexual  Person who permanently takes on the role of someone of the opposite sex; identifies entirely with opposite sex.

zygote  Fertilised egg.
Medical intervention aimed at satisfying people’s needs in respect of procreation

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LEARNING OUTCOMES

When you have completed this study unit, you should be able to

- explain the legal principles – created either by common law or statutory law – which apply to a number of medical interventions (such as sterilisation)
- discuss the legal principles which apply to additional therapeutic and non-therapeutic medical procedures governed by statutory law in South Africa, such as abortion, artificial insemination and in vitro fertilisation

8.1 Sterilisation

8.1.1 Introduction

Until the middle of the twentieth century sterilisation for convenience, that is to prevent the birth of a child, or of more children, was frowned upon socially in many countries. Thus in Bravery v Bravery [1954] 2 A11 ER 59 Denning LJ in a dissenting judgment declared that the mere objective “to have the pleasure of sexual intercourse without shouldering the responsibilities attaching to it” rendered sterilisation unlawful.

Where, on the other hand, the objective was medical or eugenic (eugenics is the scientific investigation of all factors which can improve a race), such as prevention of the transfer of a hereditary disease, the juristic attitude was more favourable.

Today it is generally accepted, also in South Africa, that sterilisation is lawful in principle. See Edouard v Administrator of Natal 1989 (2) SA 368 (D). Section 12 of our Constitution guarantees the right, inter alia, of everyone to make decisions concerning reproduction, which undoubtedly also includes the right to have him- or herself sterilised. Most of the world is in the grip of a population explosion, and family planning is regarded in many societies as laudable.
**Sterilisation** is governed in South Africa by the Sterilisation Act 44 of 1998. “**Sterilisation**” is defined as “a procedure whereby a person could be permanently rendered incapable of fertilisation or reproduction” (s 1 of the Sterilisation Act 44 of 1998).

### 8.1.2 Persons capable of consenting

A person may be sterilised if he or she is

(i) capable of consenting
(ii) 18 years or above (s 2(1)) (see 5.4.2.5)

Such a person may not be sterilised without consenting (s 2(2)).

The Act leaves no doubt that an **unmarried** person of 18 years or above may also be sterilised.

**Sterilisation** may not be performed on a person who is **under the age of 18 years**, except where failure to do so would jeopardise the person’s life or seriously impair his or her health (s 2(3)(a)). In the case of a youth under 18 years, a request must be made to the person in charge of a hospital, and the consent of the youth’s parent, spouse, guardian or curator is required (s 2(3)(b) read with s 3(1)(a)). The person in charge of the hospital must, upon request (as prescribed by the regulations under the Act) convene a panel consisting of a psychiatrist or medical practitioner if no psychiatrist is available, a psychologist or a social worker, and a nurse (s 2(3)(b) read with s 3(2)). A youth under 18 years may be sterilised if consent is given by a person who is lawfully entitled to give consent, and an independent medical practitioner who, before a panel is convened in terms of section 3(2), has consulted with the youth to be sterilised and has provided a written opinion to the effect that the **sterilisation** is in the best interest of the youth (s 2(3)(c)).

The panel has to consider all relevant information, and has to concur that a **sterilisation** may be performed on the person (s 3(1)(b)). “**Relevant information**” includes the person’s (the youth’s) age; whether there are other safe and effective alternatives to **sterilisation**; the person’s mental and physical health and wellbeing; the potential effect of **sterilisation** on the person’s mental and physical health and wellbeing; the nature of the **sterilisation** procedure to be performed; the likelihood that the person will become capable of consenting to **sterilisation**; whether the **sterilisation** is in the best interests of the person to be sterilised; and the benefit which the person may derive from **sterilisation** (s 3(1)(b)).

Contravention of these provisions constitutes a serious criminal offence (s 9). It may incur a sentence of up to five years’ imprisonment.

### 8.1.3 Persons incapable of consenting, or incompetent to consent due to mental disability

A **sterilisation** may be performed on a person who is **mentally disabled** to such an extent that he or she is incapable of

(i) making his or her own decision about contraception or **sterilisation**
(ii) developing mentally to a sufficient degree to make an informed judgement about contraception or **sterilisation**
(iii) fulfilling the parental responsibility associated with giving birth (s 3(1)(c))
“Mental disability” is defined in section 3(7) as

... a range of functioning extending from partial self-maintenance under close supervision, together with limited self-protection skills in a controlled environment through limited self care and requiring constant aid and supervision, to restrained sensory and motor functioning and requiring nursing care.

In the case of such persons sterilisation may only be performed on a request made to the person in charge of a hospital, and with the consent of a parent, spouse, guardian or curator of the patient (s 3(1)(a)). A panel, constituted as described above, must be convened. It must consider all relevant information as described above. The panel must concur that the procedure may be performed. (Note that if the patient is in custodial care, no member of the panel may be an employee of the custodial institution (s 3(3)). If the sterilisation is to be performed in a private healthcare facility, the members of the panel may not be employees of, or have a financial interest in, that facility (s 3(4)).)

The persons performing the procedure must ensure that the method of sterilisation used holds the least health risk to the person on whom the sterilisation is performed (s 3(5)).

8.1.4 Consent

For the purposes of the Sterilisation Act 44 of 1998 Act “consent” means consent given freely and voluntarily without any inducement (s 4). The patient (or other person giving the required consent, such as a parent in the situations described above) must have been given a clear explanation and adequate description of

(i) the proposed plan of the procedure
(ii) the consequences, risks and the reversible or irreversible nature of the sterilisation procedure

The persons whose consent is sought must have been given advice that the consent may be withdrawn any time before the treatment. Consent must be given by way of signing the consent form as described by ministerial regulations (see 5.2.2.2). It is expressly required that the person giving the consent must have understood the prescribed consent form.

Consent in terms of the Act therefore implies a fully informed consent. The question arises as to whose duty it is to inform the patient. It will clearly be advisable for the doctor performing the procedure to do so himself, but a practitioner is entitled to delegate his duty to a responsible person, such as a nurse. However, in the event of insufficient information being given – resulting in flawed consent by the patient – it will be the doctor who may be legally accountable. (Also see study unit 11.)

Must all the possible consequences and risks of the procedure be explained to the patient? To require that would clearly be unreasonable. We are of the opinion that the common-law criteria as to the amount of information to be imparted will probably be applied by the courts in the event of a dispute (see our discussion of consent in study unit 5).

As far as married persons are concerned there is no indication whatsoever in the Act that in the case of a spouse who is capable of consenting and seeks sterilisation, and is 18 years or older, the consent of the other spouse is also required.

Earlier in the previous century there was strong support for the view that where a spouse was
sterilised, it was necessary to obtain the consent also of the other spouse. This view proceeded
from the premise that there was a “mutual right to procreate” within the normal marriage. However,
there is very little support for this view today. The modern view is that each spouse is autonomous
as far as his or her body is concerned. Section 12 of the Constitution to which we referred above,
supports this view. In *Raath v Mukheiber* 1999 (3) SA 1065 (SCA) the court intimated by means of a
rhetorical question that a spouse has full autonomy regarding a sterilisation operation (par 48).

8.1.5 Some provisions

Sterilisation of persons incapable of consenting or incompetent to consent due to mental disability
may be performed only at a facility designated in writing for that purpose by the member of a
provincial Executive Council responsible for health (s 5).

The person in charge of such a facility must be notified of all sterilisations performed there, and
must keep adequate records (s 6).

As we have mentioned above, non-compliance with the Act will constitute a serious criminal offence
(s 9).

8.2 Abortion

8.2.1 Introduction

The legality of abortion (or it is perhaps better to say, the limits within which abortion ought to be
lawful) is still one of the most controversial issues of our times.

At the one extreme there is the view, based on religious principles, that abortion amounts to murder
of the unborn and is never justified. At the other extreme there is the view that the woman is
autonomous as far as her own body is concerned, and that the embryo or foetus is part of her body
with which she can freely do as she wishes. Between these two extremes there is a wide variety of
views on the limits within which abortion may be or ought to be justifiable.

In Roman-Dutch law abortion was legal in a single instance only, namely if continued pregnancy
threatened the woman’s life. In 1975 the legislature extended lawful abortion to include six
additional grounds or “indications” with the promulgation of the Abortion and Sterilisation Act 2 of
1975. The Act set strict requirements for pre-abortion enquiry, certification and official authorisation.

In many countries of the world, particularly in the West, the twentieth century has seen the societal
attitude towards abortion become far more lenient. This also happened in South Africa when the
Choice on Termination of Pregnancy Act 92 of 1996 was put into effect on 1 February 1997 and the
Abortion and Sterilisation Act 2 of 1975 was repealed.

In *Christian Lawyers Association of SA v Minister of Health* 1998 (4) SA 1113 (T) the court upheld
the constitutional validity of the Choice on Termination of Pregnancy Act 92 of 1996. The plaintiffs
had alleged that the Act was in conflict with section 11 of the Bill of Rights which provides:
“Everyone has the right to life.” They contended that the life of a human being starts at conception
and that abortion terminates the life of a human being. The court held that the answer to the
question whether the word “everyone” applies to an unborn child does not depend on medical or
scientific evidence as to when the life of a human being commences. Nor is it the function of a court
to decide the issue on religious or philosophical grounds. The court found that the status of the foetus under common law, particularly regarding the question whether it is a legal persona, is uncertain. Had the drafters of the Constitution wished to protect the foetus in the Bill of Rights, one would have expected this to have been done in section 28, which specifically protects the rights of the child, the judge said. Moreover, if section 11 were to be interpreted as offering constitutional protection to the life of a foetus, far-reaching and anomalous consequences would ensue. Abortion would be constitutionally prohibited even if the pregnancy constituted a serious threat to the life of the mother, or where, for example, the pregnancy resulted from rape or incest. “The drafters of the Constitution could not have intended to contemplate such far-reaching results without expressing themselves in no uncertain terms,” McCreath J said.

This approach has been widely criticised. See 1.3 above, and note the arguments of Naude and Slabbert on the sanctity of human life and our interpretation of Stewart v Botha.

8.2.2 When may pregnancy be terminated?

Priya, a woman of 42 years old, has just heard, after an amniocentesis, that her foetus has Down’s syndrome. Priya’s husband recently died in a motor vehicle accident and she is now a single parent with three other children to bring up. According to Priya she cannot afford to support a disabled child. She asks you whether she may terminate the pregnancy.

Of vital importance regarding the circumstances in which, and conditions under which, pregnancy may be terminated, is the age of the foetus. The Act distinguishes three different gestation periods:

1. the first 12 weeks
2. from the 13th up to and including the 20th week
3. after the 20th week

“Gestation period” is defined in section 1 as the period of pregnancy calculated from the first day of the menstrual period which in relation to the pregnancy is the last.
8.2.3 The first 12 weeks

During this period a pregnancy may be terminated upon request. “Woman” is defined as “any female person of any age”. Termination of pregnancy in these cases may be performed either by a medical practitioner, or a registered midwife or registered nurse who has completed the prescribed course (s 2(1)(a) read with s 2(2)).

8.2.4 From 13 to 20 weeks

There are seven indications for termination effected in this period:

1. If the continued pregnancy will pose a risk of injury to the woman’s physical health.
2. If the continued pregnancy will pose a risk of injury to the woman’s mental health.
3. If there is a substantial risk that the foetus will suffer from a severe physical abnormality.
4. If there is a substantial risk that the foetus will suffer from a severe mental abnormality.
5. If the pregnancy has resulted from rape.
6. If the pregnancy has resulted from incest.
7. If the continued pregnancy will significantly affect the social or economic circumstances of the woman (s 2(1)(b)).

A medical practitioner must, after consultation with the woman, have decided that at least one of these indications is present. Only a medical practitioner may carry out the termination (s 2(1)(b) read with s 2(2)).

In terms of the Choice on Termination of Pregnancy Act 92 of 1996 the concept of rape refers to offences in section 3 (rape), 4 (compelled rape), and 15 (statutory rape) of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007. The definitions of these offences will cover instances where pregnancy is the result of the unlawful and intentional penetration of a woman without her consent by another, irrespective of whether the person was forced to commit the act. Furthermore it will also cover the situation where a child of 12 years or older, but under the age of 16, fell pregnant due to sexual penetration, despite having given consent to penetration.

8.2.5 After the 20th week

There are three indications for termination effected in this period:

1. Where continued pregnancy would endanger the woman’s life,
2. Where continued pregnancy would result in severe malformation of the foetus.
3. Where continued pregnancy would pose a risk of injury to the foetus (s 2(1)(c)).

A medical practitioner must, after consultation with another doctor or a registered midwife or a registered nurse, have formed the opinion that at least one of these indications is present. Only a doctor may carry out the termination (s 2(1)(c) read with s 2(2)).

To return to Priya’s situation: It is clear from the information in 8.2.2 to 8.2.5 that, in terms of the Choice on Termination of Pregnancy Act, pregnancy can be terminated in certain prescribed cases. To determine which stipulations apply in respect of termination of pregnancy, it has to be determined how far the pregnancy has progressed. You must read
the indications for a lawful termination of pregnancy in each of the trimesters very carefully. Note the presence or absence of qualifying adjectives and adverbs such as “severe”, “substantial” and “significantly”. The advice you are going to give to Priya is going to depend on the stage of the gestation period.

8.2.6 Method of termination

For the purposes of the Act “termination” means the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman (s 1).

8.2.7 Place where termination may be effected

The termination of a pregnancy may only take place at a facility which

1. gives access to medical and nursing staff
2. gives access to an operating theatre
3. has appropriate surgical equipment
4. supplies drugs for intravenous and intramuscular injection
5. has emergency resuscitation equipment and access to an emergency referral centre or facility
6. gives access to appropriate transport should the need arise for emergency transfer
7. has facilities and equipment for clinical observation and access to in-patient facilities
8. has appropriate infection control measures
9. gives access to safe waste disposal infrastructure
10. has telephonic means of communication
11. has been approved by notice in the Government Gazette by the Member of the Executive Council of the relevant province who is responsible for health (s 3(1))

A health facility that has a 24-hour service and which complies with requirements (1)–(10) above, may terminate pregnancies of up to and including 12 weeks without having to obtain the approval of the Member of the Executive Council (s 3(3)(a)).

8.2.8 Counselling and informing woman

The Act imposes a duty on the State to promote the provision of non-mandatory and non-directive counselling before and after the termination of a pregnancy (s 4). The regulations promulgated in terms of the Choice on the Termination of Pregnancy Act 92 of 1996 (GNR 168 of 31 Jan 1997) contain specific stipulations in respect of counselling and informing a woman.

Stipulations in respect of the nature of the counselling:

1. Counselling should at the least include sufficient information to assist a woman to make an informed choice regarding the termination of her pregnancy.
2. A woman requesting the termination of her pregnancy shall be informed during counselling with regard to
   (a) the available alternatives to the termination of her pregnancy
   (b) the procedure and the associated risks of the termination of the pregnancy
A woman requesting the termination of her pregnancy shall also be informed that counselling is private and confidential, unless she chooses to disclose the nature or content of such counselling (Reg 7).

Stipulations in respect of the information to be furnished:

A woman requesting the termination of her pregnancy shall be informed:

1. that she is entitled to the termination of her pregnancy upon request during the first 12 weeks of the gestation period
2. that her pregnancy may be terminated from the 13th up to and including the 20th week of the gestation period if the circumstances fall within the described grounds for termination as in 8.2.4
3. that only her consent is required for the termination of her pregnancy
4. that counselling shall be available
5. of the locality of facilities for the termination of pregnancies.

The Act further places a positive obligation on a doctor, registered midwife or registered nurse who the woman requested to terminate her pregnancy, to inform her of her rights in terms of this act (s 6). Failure to do so is not per se declared as criminal offence (by s 10 that regulates offences and penalties). However, section 10 declares it an offence for someone to prevent the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy. Such conduct may lead to a fine or imprisonment of up to 10 years.

It is submitted that “preventing” or “obstructing” as envisaged by the Act requires positive conduct going far beyond a mere omission or refusal by a doctor, a midwife or a nurse to inform the woman of her rights. To regard such an omission or refusal as “preventing” or “obstructing” would in our opinion offend against the rights of freedom of speech and conscience ensconced in the Constitution.

Likewise refusal to perform a termination if required to do so, can in our opinion not be regarded as criminal conduct; there is nothing in the Act to justify such a harsh result. This is probably the reason why no “conscience clause” was embodied in the Act. In case of emergency, a duty arising from common-law or statute (National Health Act 61 of 2003, s 5) may rest on a doctor to come to a woman’s aid despite his or her objections based on religion, conscience or belief. An example of such an emergency would be where a woman were to present at a doctor’s rooms after a “botched” abortion attempted by an unskilled person, as a result of which her life or health is under serious threat. Dada MA & McQuoid-Mason DJ Introduction to medico-legal practice (2001) 73 are of the opinion that doctors and health professionals employed by the state may have to assist with terminations of pregnancy against their conscience, religion or belief where there are no other facilities available.

In our opinion there is no duty on a doctor requested by a woman to perform a (non-emergency) abortion to refer her to another doctor or facility for the performance of the procedure. The Act (s 6) goes no further than to impose a duty on a doctor to inform her of her rights under the Act. In the light of the Constitutional guarantee of freedom of religion, belief and opinion (s 15) and freedom of expression (s 16), the constitutionality of section 6 of Act 92 of 1996 may be doubtful. In Wooley v Mannured 430 US 705 (1977), the US Supreme Court held that the freedom-of-thought
constitutional provision included both the right to speak freely and the right to refrain from speaking at all.

8.2.9 Consent requirements

The regulations promulgated in terms of the Choice of Termination of Pregnancy Act 92 of 1996 (GNR 168 of 31 Jan 1997) provide that the woman who requests termination of pregnancy, as well as the doctor or registered midwife who performs the termination, must complete the standard form, prescribed in the regulations. The consent of the woman to perform the procedure for termination of the pregnancy will include consent to other medical procedures which may be necessary due to complications connected with the termination of the pregnancy (s 6).

Termination of pregnancy can in principle only take place with the informed consent of the woman (s 5(1)). The act removes all uncertainty on the question whether a woman needs her husband’s consent for termination of her pregnancy by providing that, apart from the case of a severely mentally disabled woman, or a woman in a state of continuous unconsciousness, no consent is necessary bar that of the pregnant woman (s 5(2)). Even a minor’s consent is sufficient (see 5.4.2.4), but the doctor, registered midwife or registered nurse (as the case may be) are obliged to urge the minor to first consult her parents, guardian, relatives or friends. However, the procedure may not be refused because the minor does not want to do so (s 5(3)). For the purposes of the Act minor means a woman younger than 18 years (s 1).

In Christian Lawyers Association v National Minister of Health (Reproductive Health Alliance as Amicus Curiae) 2005 (1) SA 509 (T) the plaintiff sought an order declaring the definition of “woman” in the Act unconstitutional on the ground that a girl below the age of 18 years is incapable of on her own taking an informed decision whether or not to have a termination of pregnancy which serves her best interest without parental consent. The court declined to rule thus, and upheld the constitutionality of the relevant provisions of the Act.

The consent of the pregnant woman is not required when she is severely mentally disabled or in a state of continuous unconsciousness. In these cases a parent, spouse, legal guardian or (if such persons cannot be found) a personal curator, may request and consent to the termination of her pregnancy up to and including the 20th week of gestation. In the first 12 weeks of gestation, the pregnancy may be terminated upon request; from the 13th up to and including the 20th week, it may be terminated on the grounds set out in 8.2.4 above. An additional requirement is that two doctors, or a doctor and a registered midwife or registered nurse, must have consented to the termination (s 5(4)).

The Act provides for abortion on the sole consent of two doctors, or a doctor and a registered midwife or registered nurse, upon such severely mentally disabled women or women in a state of continuous unconsciousness in the following circumstances: During the period up to and including the 20th week of gestation, the two doctors, or the doctor and the registered midwife or registered nurse, must be of the opinion that

(1) the continued pregnancy would pose a risk of injury to the woman’s physical or mental health; or
(2) there exists a substantial risk that the foetus would suffer from a severe physical or mental abnormality.

After the 20th week of gestation, they must be of the opinion that the continued pregnancy
(1) would endanger the woman’s life;
(2) would result in a severe malformation of the foetus; or
(3) would pose a risk of injury to the foetus.

Those healthcare professionals who have the authority to consent in such cases must first consult
the parent, spouse, legal guardian or personal curator, but the termination of the pregnancy shall
not be denied if such representative person(s) refuse(s) to consent (s 5(5)).

In respect of consent to termination of the pregnancy of a woman who is severely mentally disabled
or in a state of continuous unconsciousness, the regulations promulgated in terms of the Choice of
Termination of Pregnancy Act 92 of 1996 (GNR 168 of 31 Jan 1997) stipulate that the natural
guardian, spouse, legal guardian or curator personae, as the case may be, and two medical
practitioners or a medical practitioner and a registered midwife shall sign the standard form as
stipulated in the regulations (Reg 5).

8.2.10 Notification and keeping records
A record of termination of pregnancy carried out by a doctor, registered midwife or registered nurse
on a woman at any time before the end of the 20th week of the gestation period must be kept by the
practitioner concerned. The person in charge of a facility in which surgical terminations take place
must be notified of every termination. Within one month details must be mailed confidentially to the
head of the relevant provincial Health Department; the name or address of the woman involved may
not be included in these details. Only the woman herself is entitled to disclose her identity (s 7).

8.2.11 Criminal abortion
The Act creates a number of offences, but is legally largely ineffectual.

It is a serious offence for a person who is not a doctor, registered midwife or registered nurse to
terminate a pregnancy during the first 12 weeks of gestation, and for a person who is not a doctor to
terminate a pregnancy after the 12th week. Furthermore, it is a serious offence for any person to
terminate a pregnancy or allow the termination of a pregnancy at a facility other than those
mentioned under 8.2.7. Conviction of these offences may incur a maximum sentence of 10 years'
imprisonment (s 10).

From the fact that only the above instances are expressly declared criminal, and that the Act is silent
on the following situations, we take it that no offence is committed in these circumstances. Thus it is
not an offence when a doctor or midwife terminates a pregnancy after the 12th week in
circumstances not covered by the Act, for example, by not consulting with another doctor, or where
none of the indications is present. It also is not an offence for a doctor, midwife or nurse to terminate
a pregnancy without a mentally competent woman’s informed consent. It is not an offence to bring
about an abortion by means of non-medical and non-surgical methods. However, it is possible that a
doctor who contravenes the provisions of the Act which were not declared criminal, will be subjected
to disciplinary procedures, as it may be regarded as “improper or disgraceful” (see 3.8.1) for a
doctor to act in contravention of the legal provisions regulating the conduct of medical practitioners.
8.2.12 **Power of courts to interfere**

In *G v Superintendent, Groote Schuur* 1993 (2) SA 255 (C) it was held that a court of law has no discretion to order an abortion envisaged in terms of the Act then in force not to take place once the statutory provisions had been complied with. In that case the mother of a 14-year-old girl who had been raped, applied in vain for an order restraining an abortion from being performed; all the necessary certification requirements had been complied with.

8.3 **Artificial fertilisation (AF) and reproductive technology**

Although we treat artificial fertilisation under the heading of non-therapeutic procedures because it does not necessarily involve the curing of a disease from which someone is suffering, the reason for this form of fertilisation is usually that there is some or other problem which prevents normal conception.

8.3.1 **Various techniques used in reproductive technology**

8.3.1.1 **Artificial insemination, donor (AID)**

Artificial insemination of a woman with the sperm of a donor is known as AID (“artificial insemination, donor”). Ovulation can be encouraged by treating the woman with hormones, after which she is injected with the donor’s sperm, usually directly into the uterus (intra-uterine insemination). AID may be used for instance where the man is sterile or has had a vasectomy and the couple are so anxious to have a child that they are prepared to let the woman be inseminated with semen obtained from another man. It may also be used where the male is a carrier for a genetic disease, or where the woman does not have a male partner.

8.3.1.2 **Artificial insemination, husband (AIH)**

If there is a conception problem that may be obviated by artificial insemination with the husband’s semen, the procedure is known as AIH (“artificial insemination, husband”). Before a man undergoes treatment that may render him infertile (such as chemotherapy), he can have a sample of his semen stored. Should they later wish to have a child, the stored semen can be used for artificial insemination of his wife.

8.3.1.3 **In vitro fertilisation (IVF)**

*In vitro* fertilisation was done for the first time with the so-called “test tube” baby who was conceived in England and born in 1978 (as a result of the work of Drs Steptoe and Edwards). The woman, Mrs Lesley Brown, could not fall pregnant on account of an abnormal condition of her Fallopian tubes. By aspiration with a needle a ripe ovum was removed from the ovary. It was placed in a laboratory dish (the medical term is *in vitro*, ie “in glass”) and sperm from her husband was added to it. The egg was fertilised and after a few days the developing embryo was placed into the woman’s uterus. There it attached to the wall of the uterus and developed in the normal manner until the child was born.

In *in vitro* fertilisation the woman whose eggs are to be used for the purposes of fertilisation receives hormonal treatment to stimulate her ovaries so that multiple eggs are produced. The eggs are then
harvested and placed in a culture to allow them to mature further. The mature eggs are placed in a petri dish, and the semen of a donor or the woman’s husband is added. The fertilised eggs (zygotes) are then placed in the woman’s uterus.

**Gamete intrafallopian transfer**

This technique has already been explained in 7.6.2. The eggs (retrieved in the manner used in *in vitro* fertilisation) are mixed with sperm and injected into the woman’s Fallopian tube(s).

**Intracytoplasmic sperm injection (ICSI)**

In intracytoplasmic sperm injection, a single sperm is injected into an egg with a very fine glass needle. If it results in fertilisation, the zygote is transferred to the woman’s uterus in the same way as in *in vitro* fertilisation. This technique is applied if a man’s sperm is unable to penetrate an egg, his sperm count is very low, or his sperm has poor motility. If a man’s semen (ejaculate) contains no sperm at all, sperm can sometimes be removed from his testes with a needle and used in ICSI.

**Statutory regulation**

**Introduction**

Artificial fertilisation is a lawful procedure, provided it is performed in accordance with the National
Health Act 61 of 2003 and the regulations promulgated by the Minister of Health in terms of that Act (published in GN R175, GG35099 of 2 March 2012.

In terms of the National Health Act 61 of 2003 a person may use gametes removed from a living person only for such purposes as may be prescribed (s 56(1)). Gametes may only be removed from a living person for such purposes if the person from whom the gametes are removed has granted his or her consent in writing on the prescribed form and it is done in accordance with the prescribed conditions (s 55).

The Act stipulates that gametes may not be removed from a person who is mentally ill (within the meaning of the Mental Health Care Act 17 of 2002) or a person younger than 18 years for any of the prescribed purposes (s 56(2)(a)(i) and (iii)) unless the Minister has authorised such removal (s 56(2)(b)).

The regulations only apply to the withdrawal of gametes from living persons and for use in living persons (Reg 2). (The regulations are rather lengthy. We only discuss those that are important for the purposes of this module.)

The regulations define “artificial fertilisation” as “the introduction by other than natural means of a male gamete or gametes into the internal reproductive organs of a female person for the purpose of human reproduction”. The following techniques are explicitly included within the definition of artificial fertilisation:

- **artificial insemination** – “the placing of male gametes (sperm) into the female reproductive tract by means other than copulation”
- **in vitro fertilisation** – “the process of spontaneous fertilisation of an ovum with a male sperm outside the body in an authorised institution”
- **gamete intrafallopian transfer** – not defined in the regulations (however, see our explanation in 8.3.1.4 above)
- **embryo intrafallopian transfer** – not defined in the regulations (presumably used to refer to the transfer of an egg that has already been fertilised before being transferred into the Fallopian tube(s))
- **intracytoplasmic sperm injection** – “the process of microscopic technology to bring about fertilisation of an ovum with a male sperm outside the body in an authorised institution”

### 8.3.2.2 Authorised persons

No person except a competent person may remove or withdraw a gamete or cause a gamete to be removed or withdrawn from the body of a gamete donor for the purpose of artificial fertilisation (Reg 3(1)). A competent person is a person registered as such in terms of the Health Professions Act 56 of 1974. Only a medical practitioner specialising in gynaecology with training in reproductive medicine, or a medical scientist, medical technologist, clinical technologist with training in reproductive biology and related laboratory procedures qualifies to be competent person.

### 8.3.2.3 Informed consent of the donor

Comprehensive written consent must be obtained from the prospective donor.

The donor must consent to the following:

1. a physical examination and questioning by a competent person
(2) the removal or withdrawal of gametes for testing, analysing or processing as the competent person may deem necessary

(3) certain personal details of himself or herself being made available to the recipient, the competent person who is to perform the artificial fertilisation, the Director-General of Health, and the central data bank (Reg 6(e)(iii)–(v)).

8.3.2.4 Limitation on the number of children that may be conceived with a donor’s gametes

If a competent person has information or suspects that a maximum of six children have been conceived by means of artificial fertilisation with a donor’s gametes, he or she may not remove or withdraw a gamete from the body of that donor, or cause such removal or withdrawal (Reg 6(a)). The donor must also be informed that no further donation may be made by him or her (Reg 6(b)). All information relating to such gamete donor must immediately be relayed to a central data bank that must be established for the storing of all information regarding gamete and embryo donations (Reg 6(c) and 5). In the case of a known donor, the competent person must ascertain from the central data bank that not more than six children have been conceived through the artificial fertilisation of a person with the gametes of that gamete donor (Reg 7(c)). The competent person must also obtain a signed statement from the gamete donor stating whether he or she has previously made a donation of gametes, and, if so, where and when that took place (Reg 7(d)).

8.3.2.5 Medical tests and examinations

The competent person must ascertain that the prospective gamete donor concerned has on two occasions, not more than three months apart and one month prior to the donation undergone a medical test for sexually transmissible diseases, and, in the case of a male donor, a semen analysis (Reg 7(g)). It must also be ascertained whether a female gamete donor has undergone a gynaecological examination prior to stimulation for the withdrawal of gametes (Reg 7(h)). The competent person further has to question the gamete donor concerning his or her family history, especially with regard to any possible genetic condition or carrier status and mental illness in respect of any child, brother, sister, parent or grandparent of such gamete donor (Reg 7(i)). In the event of a request in respect of which the donor and recipient are known to each other, the competent person must ensure that both parties are psychologically evaluated, and both parties confirm in writing that they know each other (Reg 7(j)).

8.3.2.6 The donor file and the information recorded therein

A competent person who intends to remove or withdraw a gamete, or cause a gamete to be removed or withdrawn from the body of a gamete donor, must, before such removal or withdrawal open a gamete donor file if such a file has not previously been opened in respect of that gamete donor (Reg 7(a)).

The donor file kept by the competent person who handles the donation must contain an entire range of very specific details provided for in the regulations (Reg 8). Inter alia particulars of any evaluation of the psychological suitability of the gamete donor to donate a gamete must be recorded (Reg 8(1)(c)). The donor’s wishes in respect of the number of artificial fertilisations for which his or her gametes may be used, must also be recorded (Reg 8(1)(a)(iv)).
The donor file must be kept in safe custody. Certain prescribed details must be made available or be furnished to the recipient, the competent person who is to effect the artificial fertilisation, and the central data bank (Reg 8(2)(b) and (c)). No other person may be furnished with any details on file, except where it is provided otherwise by law or if a court so orders (Reg 8(2)(d)).

8.3.2.7 Compensation in respect of gamete donation allowed?

The donor may be reimbursed for any reasonable expenses incurred by him or her in order to effect the donation (Reg 4 and s 60(4)(a) of the National Health Act 61 of 2003). A gamete donor commits an offence in terms of section 60(4)(a) of the National Health Act 61 of 2003 if he or she receives any form of financial or other reward for such donation. (Obviously, the reimbursement for reasonable expenses to which we have referred above does not constitute an offence – s 60(4)(a).) The offence created in terms of section 60(4)(a) is punishable with a fine or imprisonment for a period not exceeding five years, or both a fine and such imprisonment (s 60(5)).

The provisions set out above relate to the donation of a gamete for the purpose of artificial fertilisation. The regulations also govern the artificial fertilisation and embryo transfer as such.

8.3.2.8 Where and by whom?

Artificial fertilisation and embryo transfer may only be effected at an authorised institution (Reg 9(1)). Artificial fertilisation may only be effected by a competent person (Reg 9(2)).

8.3.2.9 Prohibition against use of certain gametes for AF

The regulations prohibit the use of a gamete

- that has not been imported, removed or withdrawn in terms of the provisions of the Act or the regulations
- from a gamete donor of whom the results of the tests for sexually transmissible diseases, semen analysis or physical examination referred to above are not available yet
- from a gamete donor younger than 18 years of age, except where a medical indication exists for artificial fertilisation (Reg 10(1)(a)–(c)).

A competent person may not effect an artificial fertilisation except for embryo transfer to a specific recipient. Embryo transfer is defined as “the placing of the embryo into the uterus or fallopian tube of the recipient”. Such an artificial fertilisation may only be effected by the union of gametes removed or withdrawn from the bodies of

- such recipient and an individual male gamete donor, or
- an individual male and an individual female gamete donor (Reg 10(2)(a))

8.3.2.10 Embryos to be stored in frozen or cryopreserved state

The embryo destined for artificial fertilisation must be stored in a frozen/cryopreserved state in a prescribed institution (Reg 10(2)(b)).
8.3.2.11 Destruction of embryos

A competent person must destroy an embryo as soon as the recipient for whom that embryo has been produced conceives or as soon as it is decided not to go ahead with the embryo transfer into that recipient (Reg 10(2)(c)). Provision is made for two exceptions, namely where (1) the competent person decides with the informed consent of the recipient to store such embryo for a further period for the purpose of a subsequent embryo transfer to that recipient, or (2) the recipient consents in writing that the competent person may use such embryo for transfer to another specific recipient, or for another purpose stated in the consent (Reg 10(2)(c)(i) and (ii)). A competent person is obliged to destroy an embryo if it has been unclaimed by the recipient for a period of ten years (Reg 10(2)(d)).

8.3.2.12 Informed consent of the recipient

The informed consent of the recipient must be obtained for:
- physical examination and questioning by a competent person
- the removal or withdrawal of a gamete from the body of the donor for the purpose of such testing, analysing or other processing as the competent person may deem necessary
- artificial fertilisation of or embryo transfer to herself, and
- the furnishing of certain particulars to the central data bank (Reg 11(b)).

8.3.2.13 Competent person’s obligation to ensure adherence to the wishes of the donor and recipient

The competent person intending to effect the artificial fertilisation or embryo transfer has the responsibility to ensure compliance with the gamete donor’s wishes in respect of the number of artificial fertilisations for which his or her gametes may be used, and the recipient’s wishes in respect of the population group to which the gamete donor should belong, the religion which he or she should profess, and any other wish concerning the gamete donor (Reg 11(c)(i) en (ii)).

8.3.2.14 Competent person’s responsibilities regarding certain tests for genetic conditions

The competent person must further ensure that certain tests are done to determine whether the gamete donor is a carrier of a serious genetic condition. If so, the competent person must ensure that no gamete of the donor is used for artificial fertilisation or embryo transfer (Reg 11(c)(iii)). If it is determined that the recipient is a carrier of a genetically transmissible disorder, the competent person must ensure that she is informed about the implications thereof (Reg 11(c)(iv)). If it is determined that the donor is, or may probably be, a carrier of a genetically transmissible disorder, the competent person must ensure that no gamete from that donor is used for artificial fertilisation, or the competent person who was responsible for the removal or withdrawal of the donor’s gamete is informed that the donor is, or probably may be, such a carrier (Reg 11(c)(iv)).

8.3.2.15 Transfer of more than three zygotes or embryos prohibited

The transfer of more than three zygotes or embryos to a recipient during an embryo transfer procedure is prohibited, unless here is a specific medical indication to the contrary (Reg 12). (See also 7.6.2 above for the MRC’s recommendation in this regard.) It would seem that this prohibition
8.3.2.16 Testing with a view to sex selection prohibited
Pre-implantation and prenatal testing for selecting the sex of a child is prohibited except in the case of a serious sex-linked or sex-limited genetic condition (Reg 13).

8.3.2.17 Recipient file and the information recorded therein
A competent person who intends to artificially inseminate a recipient must open a personal recipient's file in which a series of details prescribed in the regulations must be recorded (Reg 11(a)). These include details of medical examinations and tests, and written consent. A recipient then gets a unique identification number.

A proper recipient file must be kept containing all the prescribed information (Reg 14). Particulars regarding tests done in respect of the recipient for sexually transmissible infections and communicable diseases should inter alia be recorded in the file. Proper confidentiality must be maintained at all times. If evaluation of the recipient's psychological or social suitability for artificial fertilisation is indicated, particulars regarding such evaluation should also be recorded. In the case of in vitro fertilisation or embryo transfer, the number of embryos produced for the embryo transfer to the recipient, the number of embryos used for each embryo transfer procedure, the number of embryos in storage, the number of embryos used for purposes other than embryo transfer, and the number of embryos destroyed must be recorded in the recipient file (Reg 14(1)(g)). The regulations contain provisions aimed at ensuring that the information in the recipient file is kept confidential. Certain particulars must, however, be made available to the central data bank every January (Reg 14(2)).

8.3.2.18 Obligation to report certain information
The person in charge of the facility where a delivery resulting from artificial fertilisation has taken place must record such birth into the central data bank within three months of such birth (Reg 16(1)(a)). Any genetic disorder or birth defect in the child must also be recorded. The woman who gives birth to the child must inform the competent person who effected the artificial fertilisation or embryo transfer of the birth and certain other particulars (Reg 16(1)(b) and (2)). If it comes to the notice of the authorised institution responsible for effecting an artificial fertilisation or embryo transfer that the child born as a result of such artificial fertilisation displays any genetic disorder or suffers from any mental illness, it must determine if the cause of the disorder or mental illness can be traced back to the gamete donor or the recipient. If the disorder or mental illness is traced back to the gamete donor, the authorised institution that effected the donation of gametes must be notified (Reg 17(1)).

8.3.2.19 Offence
Contravention of any provision in the regulations constitutes an offence (Reg 21). The offence is punishable with a fine or imprisonment for a period not exceeding 10 years, or to both such fine and imprisonment.
8.3.3 The legal position of a child conceived in consequence of artificial fertilisation

Whenever the gamete or gametes of any person have been used for the artificial fertilisation of a woman, any child born of the woman as a result of such artificial fertilisation must for all purposes be regarded to be the child of that woman (Children’s Act 38 of 2005, s 40(2)).

This provision clearly pertains to any child born as a result of AID, AIH or any procedure whereby use was made of the gamete of another woman.

Mrs Van Eck wants to have a child of her own, but Mr Van Eck is sterile. Mrs Van Eck’s desire to have a baby of her own is so strong that she is willing to be inseminated with the sperm of another man, but Mr Van Eck is opposed to AID. Mrs Van Eck visits a fertility clinic and is inseminated with the sperm of a donor, Mr Da Gama. Is the child born in consequence of this procedure deemed to be the child of Mr and Mrs Van Eck? Is there any legally recognised relationship between Mr Da Gama and baby Van Eck?

It should at this point already be clear to you that the child is for all purposes regarded as Mrs Van Eck’s child. But is the child also deemed to be that of Mr Van Eck?

Section 40(1)(a) stipulates that if the gamete or gametes of any person other than a married person or his or her spouse have been used with the consent of both such spouses for the artificial fertilisation of one spouse, any child born of that spouse as a result of such artificial fertilisation must for all purposes be regarded to be the child of those spouses (as if the gamete or gametes of those spouses had been used for such artificial fertilisation). It is presumed by law that both spouses have granted consent until the contrary is proved (s 40(1)(b)).

No right, responsibility, duty or obligation arises between, on the one side, a child born of a woman as a result of artificial fertilisation, and on the other, any person whose gamete has or gametes have been used for such artificial fertilisation or the blood relations of that person (s 40(3)). This rule does not apply where the gamete donor was the woman who gave birth to the child, or her husband. (Note that the position as set here out does not apply where a surrogate motherhood agreement exists – see 8.4.6 below.)

8.3.4 Potential liability of the doctor

We again draw your attention to the fact that contravention of any provision in the regulations constitutes an offence (see 8.3.2.19). Obviously, a doctor or other competent person may also incur criminal liability for contravention of the regulations.

As far as the liability of the doctor is concerned some factors of a more academic nature come into play. If the medical practitioner who performs the artificial insemination acts with the consent of both spouses, there is little danger of delictual or criminal liability, whether the donor of the semen is the spouse or another man. In our opinion, if the medical practitioner acts without the consent of the woman, his or her conduct amounts to a serious iniuria against the woman, which may incur both civil and criminal liability.
There is a distinct possibility that if a semen donor is HIV-positive, the woman who is artificially fertilised and/or her child may be infected. (An American case was reported in 1990 of the wife of a haemophiliac who became infected with the AIDS virus after undergoing artificial insemination in an effort to conceive a child. Her husband’s semen had been used [The Citizen, 21/4/90].) Depending on the circumstances and the proof of negligence, the donor and/or the agency supplying the semen may be held liable for damages. The possibility that the competent person who performed the insemination might incur liability cannot be excluded.

If a doctor is negligent in using semen, for example by obtaining it from a donor with a venereal disease or who is too closely related to the recipient, so that a defective child is born, there is a possibility of liability on the basis of wrongful birth (which is discussed in 11.4 below).

Where a doctor has agreed with a married couple to inseminate the woman with semen obtained from a donor who belongs to a particular faith or ethnic group, but fails to do so, there may be liability arising from breach of contract. But proof of damage or loss may be an insurmountable obstacle for the couple.

8.4 Surrogate motherhood agreements

Before chapter 19 of the Children’s Act 38 of 2005 came into operation on 1 April 2010, there was no legislation expressly regulating surrogacy agreements. The approach followed was to consider these against the background of the boni mores. Surrogacy agreements are now recognised and regulated in terms of the Children’s Act 38 of 2005.

The concept of “surrogate mother” and “surrogate motherhood agreement” are defined in the definition section of the Children’s Act 38 of 2005 as follows:

<table>
<thead>
<tr>
<th>“Surrogate mother”</th>
<th>means an adult woman who enters into a surrogate motherhood agreement with the commissioning parent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Surrogate motherhood agreement”</td>
<td>means an agreement between a surrogate mother and a commissioning parent in which it is agreed that the surrogate mother will be artificially fertilised for the purpose of bearing a child for the commissioning parent and in which the surrogate mother undertakes to hand over such a child to the commissioning parent upon its birth, or within a reasonable time thereafter, with the intention that the child concerned becomes the legitimate child of the commissioning parent.</td>
</tr>
</tbody>
</table>

The surrogate motherhood agreement has to fulfil the following requirements.

8.4.1 Nature of the agreement

In respect of the nature of the agreement, section 292 of the Children’s Act 38 of 2005 stipulates as follows:

1) No surrogate motherhood agreement is valid unless
   (a) the agreement is in writing and is signed by all the parties thereto
   (b) the agreement is entered into in South Africa
(c) at least one of the commissioning parents, or where the commissioning parent is a single person, that person, is at the time of entering into the agreement domiciled in South Africa
(d) the surrogate mother and her husband or partner, if any, are at the time of entering into the agreement domiciled in South Africa, and
(e) the agreement is confirmed by the High Court within whose area of jurisdiction the commissioning parent or parents are domiciled or habitually resident.

8.4.2 Consent

In respect of consent section 293 of the Act stipulates that consent of the husband, wife or partner has to be obtained in the following circumstances:

(1) Where a commissioning parent is married or involved in a permanent relationship, the court may not confirm the agreement unless the husband, wife or partner of the commissioning parent has given his or her written consent to the agreement and has become a party to the agreement.

(2) Where the surrogate mother is married or involved in a permanent relationship, the court may not confirm the agreement unless her husband or partner has given his or her written consent to the agreement and has become a party to the agreement.

(3) Where a husband or partner of a surrogate mother who is not the genetic parent of the child unreasonably withholds his or her consent, the court may confirm the agreement.

8.4.3 Genetic origin of the child

No surrogate motherhood agreement is valid unless the conception of the child contemplated in the agreement is to be effected by the use of the gametes of both commissioning parents or, if that is not possible due to biological, medical or other valid reasons, the gamete of at least one of the commissioning parents or, where the commissioning parent is a single person, the gamete of that person (s 294).

8.4.4 Circumstances under which the court will be prepared to confirm the surrogate motherhood agreement

The Act also sets out the circumstances under which the court will be prepared to confirm the surrogate motherhood agreement.

In terms of section 295, a court may not confirm a surrogate motherhood agreement unless

(a) the commissioning parent or parents are not able to give birth to a child and the condition is permanent and irreversible

(b) the commissioning parent or parents

   (i) are in terms of this Act competent to enter into the agreement

   (ii) are in all respects suitable persons to accept the parenthood of the child that is to be conceived, and

   (iii) understand and accept the legal consequences of the agreement and this Act and their rights and obligations in terms thereof
(c) the surrogate mother

(i) is in terms of this Act competent to enter into the agreement
(ii) is in all respects a suitable person to act as surrogate mother
(iii) understands and accepts the legal consequences of the agreement and this Act and her rights and obligations in terms thereof
(iv) is not using surrogacy as a source of income
(v) has entered into the agreement for altruistic reasons and not for commercial purposes
(vi) has a documented history of at least one pregnancy and viable delivery, and
(vii) has a living child of her own

(d) the agreement includes adequate provisions for the contact, care, upbringing and general welfare of the child that is to be born in a stable home environment, including the child’s position in the event of the death of the commissioning parents or one of them, or their divorce or separation before the birth of the child, and

(e) in general, having regard to the personal circumstances and family situations of all the parties concerned, but above all the interests of the child that is to be born, the agreement should be confirmed.

8.4.5 Circumstances under which artificial fertilisation of the surrogate mother may occur

The Act also prescribes in section 296 the circumstances under which artificial fertilisation of the surrogate mother may occur:

(1) No artificial fertilisation of the surrogate mother may take place

(a) before the surrogate motherhood agreement is confirmed by the court
(b) after the lapse of 18 months from the date of the confirmation of the agreement in question by the court.

(2) Any artificial fertilisation of a surrogate mother in the execution of an agreement contemplated in this Act must be done in accordance with the provisions of the National Health Act 61 of 2003.

8.4.6 Status of the child

What are the consequences of surrogate motherhood for the status of the child? The Act expressly provides in section 297 as follows:

(1) The effect of a valid surrogate motherhood agreement is that

(a) any child born of a surrogate mother in accordance with the agreement is for all purposes the child of the commissioning parent or parents from the moment of the birth of the child concerned
(b) the surrogate mother is obliged to hand the child over to the commissioning parent or parents as soon as is reasonably possible after the birth
(c) the surrogate mother or her husband, partner or relatives has no rights of parenthood or care of the child
(d) the surrogate mother or her husband, partner or relatives have no right of contact with the child unless provided for in the agreement between the parties

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subject to sections 292 and 293, the surrogate motherhood agreement may not be terminated after the artificial fertilisation of the surrogate mother has taken place, and the child will have no claim for maintenance or of succession against the surrogate mother, her husband or partner or any of their relatives.

(2) Any surrogate motherhood agreement that does not comply with the provisions of this Act is invalid and any child born as a result of any action taken in execution of such an arrangement is for all purposes deemed to be the child of the woman that gave birth to that child.

8.4.7 Circumstances under which such surrogate motherhood agreement may be terminated

The Act also makes provision for the circumstances under which such surrogate motherhood agreement may be terminated, and sets out the consequences of such termination (s 298).

(1) A surrogate mother who is also a genetic parent of the child concerned may, at any time prior to the lapse of a period of sixty days after the birth of the child, terminate the surrogate motherhood agreement by filing written notice with the court.

(2) The court must terminate the confirmation of the agreement in terms of section 295 upon finding, after notice to the parties to the agreement and a hearing, that the surrogate mother has voluntarily terminated the agreement and that she understands the effects of the termination, and the court may issue any other appropriate order if it is in the best interest of the child.

(3) The surrogate mother incurs no liability to the commissioning parents for exercising her rights of termination in terms of this section, except for compensation for any payments made by the commissioning parents in terms of section 301.

8.4.8 Effect of termination of surrogate motherhood agreement

The Act provides in section 299 for the effect of the termination of a surrogate motherhood agreement. The effect of such termination is that

(a) where the agreement is terminated after the child is born, any parental rights established in terms of section 297 are terminated and vest in the surrogate mother, her husband or partner, if any, or if none, the commissioning father

(b) where the agreement is terminated before the child is born, the child is the child of the surrogate mother, her husband or partner, if any, or if none, the commissioning father, from the moment of the child’s birth

(c) the surrogate mother and her husband or partner, if any, or if none, the commissioning father, is obliged to accept the obligation of parenthood

(d) subject to paragraphs (a) and (b), the commissioning parents have no rights of parenthood and can only obtain such rights through adoption, and

(e) subject to paragraphs (a) and (b), the child has no claim for maintenance or of succession against the commissioning parents or any of their relatives.

8.4.9 Abortion in surrogacy

(1) A surrogate motherhood agreement is terminated by a termination of pregnancy that may be carried out in terms of the Choice on Termination of Pregnancy Act 92 of 1996.
(2) For the purposes of the Choice on Termination of Pregnancy Act 92 of 1996, the decision to terminate lies with the surrogate mother, but she must inform the commissioning parents of her decision prior to the termination and consult with the commissioning parents before the termination is carried out.

(3) The surrogate mother incurs no liability to the commissioning parents for exercising her right to terminate a pregnancy pursuant to this section except for compensation for any payments made by the commissioning parents in terms of section 301 where the decision to terminate is taken for any reason other than on medical grounds (s 300).

### 8.4.10 Compensation for surrogacy

Compensation for surrogacy is prohibited in section 301:

1. Subject to subsections (2) and (3), no person may in connection with a surrogate motherhood agreement give or promise to give to any person, or receive from any person, a reward or compensation in cash or in kind.

2. No promise or agreement for the payment of any compensation to a surrogate mother or any other person in connection with a surrogate motherhood agreement or the execution of such an agreement is enforceable, except a claim for
   - (a) compensation for expenses that relate directly to the artificial fertilisation and pregnancy of the surrogate mother, the birth of the child and the confirmation of the surrogate motherhood agreement
   - (b) loss of earnings suffered by the surrogate mother as a result of the surrogate motherhood agreement, or
   - (c) insurance to cover the surrogate mother for anything that may lead to death or disability brought about by the pregnancy.

3. Any person who renders a bona fide professional legal or medical service with a view to the confirmation of a surrogate motherhood agreement in terms of section 295 in the execution of such an agreement, is entitled to reasonable compensation therefor.

### 8.4.11 Confidentiality

In respect of the identity of the parties, the Act expressly provides that the identity of the parties to court proceedings with regard to a surrogate motherhood agreement may not be published without the written consent of the parties concerned. Furthermore no person may publish any facts that reveal the identity of a person born as a result of a surrogate motherhood agreement (s 302).

### 8.4.12 Offences in respect of surrogacy

The Children’s Act also provides in section 303 that

1. no person may artificially fertilise a woman in the execution of a surrogate motherhood agreement or render assistance in such artificial fertilisation, unless that artificial fertilisation is authorised by a court in terms of the provisions of this Act.

2. no person may in any way for or with a view to compensation make known that any person is or might possibly be willing to enter into a surrogate motherhood agreement.
Contravention of these provisions constitutes an offence (s 305(1)(b)). This offence is punishable with a fine or imprisonment for a period not exceeding ten years, or to both a fine and such imprisonment (s 305(6)).

8.4.13 Miscellaneous matters pertaining to surrogacy

No regulations were promulgated with this Act, but the Judge-president of the Gauteng High Court issued a practice directive on handling applications for confirmation of surrogacy agreements. The problems surrounding these types of applications were highlighted in the first reported court finding in this regard, namely *Ex Parte Applications for the Confirmation of three Surrogate Motherhood Agreements* 2011 (6) SA 22 (GSJ). Here Wepener J and Victor J postponed the applications *sine die* because they were in many respects confusing and did not contain the required information – the parties were given the opportunity to amend the applications so that the court could hear the matter on merit.

In its decision the court made it clear that complete and full compliance with all the provisions of the Act as well as the requirements raised in the present judgment are required for a valid surrogacy agreement. Each such agreement is unique and must take the circumstances of the parties into consideration. The following practical guidelines were given in this case:

- In general surrogacy agreements are not regarded as urgent; in other words, applications should not be brought to court on a basis of urgency.
- The confirmation by the court of a surrogacy agreement is not merely a rubber stamp that will be granted as a matter of course.
- As upper guardian of all minors the court has a constitutional and international legal obligation to ensure that children’s interests have precedence, and it should therefore take this obligation very seriously.
- The success of an application will depend on the evidence about the facts before the court on which the application are based, so that the court may reach a decision in terms of statutory requirements.
- All expert reports must be compiled with care and be totally reliable. The facts in respect of which any recommendation based on expert support is offered, must be set out in great detail.

The facts and evidence must refer to the general and specific circumstances relevant to the parties (the surrogate mother, the commissioning parents, the person appointed by the latter in case of their demise), their financial means and emotional stability, whether they are able to be primary carers of the child, and the permanency or reversibility of the sterility of the commissioning parents. It was also recommended that before concluding such agreement there should be psychological screening of both the surrogate mother and the commissioning parents, as well as a full physical examination of the surrogate mother. In addition evidence must be brought to the court that the requirements in respect of the welfare of the child, once it is born, will be fulfilled, including making a will, and professional evaluation of the commissioning parents’ home environment. Lastly the court pointed out that the parties will have to prove (although it will not form part of the agreement) that they did not commit any of the prohibited acts as set out in section 303 of the Act, concerning artificial insemination and compensation (s 303).

In September 2011 a surrogacy agreement between a homosexual couple and the mother who was pregnant with their child was approved and confirmed by the North-Gauteng High Court. Tolmay J
and Kollapen J also lay down strict guidelines for consideration of such agreements by the courts in order to ensure consequent consideration and practice in respect of such matters. The application for the court to confirm the surrogacy agreements was brought by the homosexual couple who was married the previous year, the surrogate mother, and her life partner. The surrogate mother and the homosexual couple were introduced by an online-agency for donor eggs, but no fee was paid for the introduction. The homosexual couple had previously obtained a court order confirming the surrogacy agreement, but the mother had to withdraw from that contract because she fell ill.

The court emphasised the following:

- In all cases where an agency is involved the courts have to be fully informed about the agency in order to avoid commercial surrogacy.
- Involvement of agencies has to be regulated and supervised in order to prevent abuse of in particular indigent women.
- Care should be taken not to apply different tests that may be seen as discriminatory in respect of same-sex couples – as in some cases it is required that the child has to be subjected to “motherly influences”. The court continued:

  The mothering of a child is a function that very often does not have anything to do with the gender of the parent. In any event, many children grow up without a father or a mother and the court should safeguard that it does not try and create a utopia for children born from surrogacy that is far removed from the social reality of society.

- Care should be taken that the rights of the commissioning parents are not violated by unnecessary infringement of their privacy by making the stakes too high for parents whose only option is to get a child by means of surrogate motherhood.

**ACTIVITIES**

1. What are the permissible limits within which a pregnancy may be lawfully terminated?

2. How would you respond to the questions posed in the green box in 8.2.1?

3. Answer the following multiple-choice question: The Choice on Termination of Pregnancy Act makes certain acts punishable. Which one of the following instances definitely amounts to an offence?

   (1) A midwife terminates a woman’s pregnancy at the woman’s request in the ninth week of gestation.

   (2) A medical practitioner terminates a woman’s pregnancy in the seventh week of gestation at a place which has no telephonic means of communication.

   (3) A medical practitioner terminates a woman’s pregnancy in the 37th week of gestation in the absence of any indication for the termination of pregnancy.

   (4) A nurse terminates a 13 year old girl’s pregnancy in the eighth week of gestation without the consent of the girl’s parents.

4. There are many couples who experience physiological problems when trying to conceive. Modern medical science has developed several techniques of assisting couples to fulfil their desire. Name these techniques, briefly explain what they entail, and state whether they are governed by legislation and/or regulations.
5. Boris (Activity 3, study unit 7) has since had the description of his sex in the birth register changed to “female”. He also changed his name to “Doris”. Doris wants to have children. She plans to have a sex change operation in order to align her sexual characteristics with her sex description, but would like to have a child of her own, or, preferably, two. She does not have any ovaries, but still has her testicles. She consults doctor Gene Joiner, fertility specialist. Doris wants her sperm to be used to artificially fertilise the eggs of a donor. Her sister, Anna, has offered to serve as surrogate mother, but she seriously doubts whether her husband would agree to this arrangement. Doris would like to have two daughters. She requests Dr Gene Joiner to determine the sex of the embryos before the embryo transfer is done, and to ensure that only embryos of the female sex are transferred to Anna’s womb. Dr Joiner is not sure how to handle Doris’ request, and visits you for some advice. It is a bit unclear to her how the provisions of the National Health Act, the Children’s Act and the regulations promulgated under these Acts fit together.

Explain to Dr Gene Joiner

(a) whether the Children’s Act 38 of 2005 contains any provisions regulating the artificial fertilisation of Anna
(b) what the National Health Act 61 of 2003 and the regulations promulgated under the Act stipulate in respect of
   (i) consent to be obtained beforehand
   (ii) any tests or examinations that have to be done beforehand
(c) if she would expose herself to any risk of liability by effecting the artificial fertilisation of Anna
(d) whether the consent of Anna’s husband is required for concluding a surrogate motherhood agreement
(e) whether surrogacy is permissible where Doris as commissioning parent is single
(f) whether she should first wait for the court to confirm the surrogate motherhood agreement before effecting the artificial fertilisation of Anna
(g) whether Anna could terminate the surrogate motherhood agreement after having been artificially fertilised
(h) she should heed Doris’ request in respect of the sex of the embryos to be transferred to Anna’s womb
(i) whether Doris may decide at will to have the pregnancy terminated in the first 12 weeks of gestation

FEEDBACK

1. The permissible limits of abortion, that is termination of pregnancy, on medical, social and other grounds, are set out fully in the Choice of Termination of Pregnancy Act 92 of 1996 which we discuss fully in 8.2 of this study unit. It is important to note that the gestational stage of the foetus plays an important role in regard to determining (a) whether in a given case termination may take place, and (b) who would be entitled to perform the procedure.

2. Don’t expect any quick and ready answers from your lecturers here! It is vital that you develop a critical approach to the law. As a(n) (aspiring) lawyer, but also as responsible citizen, you have a duty to reflect independently on social issues and to participate in public debate. No democracy can flourish unless the citizenry is
informed and delivers input in the legislative process. As a(n) (aspiring) lawyer, you must continuously work at developing your ability to persuade others of a particular point of view through the use of well-informed, closely reasoned, and eloquent arguments. While language is a lawyer’s tool, persuasion is his art. However, if your argument is devoid of a strong factual basis, it will come across to an informed listener as hollow rhetoric or an emotional appeal – so make sure that you are abreast of all the facts! A simple remark such as: “I am for/against abortion/euthanasia/the death penalty,” does not distinguish you from any lay-person. “The devil is in the detail”, it is sometimes said. Use your more extensive knowledge of the law to formulate a more concrete and sophisticated argument.

3. The correct answer is (2). See 8.2.1.1. Note that you had to identify the single instance that definitely constitutes an offence. Some of these options contain insufficient details for you to be able to establish with certainty that the conduct amounts to an offence.

(1) See 8.2.3. The woman’s request is sufficient.
(2) It is a serious offence to terminate a pregnancy at a facility that does not meet the prescribed requirements. See 8.2.7 and 8.2.3.
(3) See 8.2.6. You might perhaps instinctively feel that the doctor’s conduct should constitute an offence, but the Act does not declare such conduct to be an offence. The possibility exists that the abortion might have been performed at a facility that does not comply with the prescribed requirements, as in option (2). Since it is not stated that the abortion is performed at such a facility, the possibility that it might have been performed at an approved facility cannot be excluded, in which case the abortion would not constitute an offence. Therefore, you cannot say with certainty that the doctor’s conduct constitutes an offence.
(4) The consent of the girl’s parents is not required, and the girl’s request is sufficient reason for the termination of the pregnancy. See 8.2.3 and 8.2.9. Remember that the nurse must have been registered as such and must have completed the prescribed course. The same goes for the midwife in option (1).

4. The techniques are artificial insemination (AID and AIH), in vitro fertilisation, gamete intrafallopian transfer, and intracytoplasmic sperm injection. The techniques are discussed in 8.3.1. The National Health Act and the regulation promulgated under the Act govern artificial fertilisation. “Artificial fertilisation” is used as an umbrella term covering all the above-mentioned techniques. See 8.3.2. The regulations also govern the actual placing of the embryo or zygote that has been created outside a woman’s body into the woman’s Fallopian tube(s) or uterus. Note that the regulations do not define all these techniques.

5. This is a very complex scenario. However, answering these questions is easier than it would seem. Just work through the question’s subdivisions in a systematic way, and answer exactly what is being asked. We want to test whether you are able to work your way through the many provisions relevant to this scenario. In so doing, you will get a good idea how artificial fertilisation, surrogate and termination of pregnancy fit together.

(a) Note that this question deals specifically with the provisions of the Children’s Act. The Children’s Act governs surrogacy, but also the artificial fertilisation of the surrogate mother. See 8.4.5. The Children’s Act further requires that the artificial fertilisation of the surrogate mother be done in accordance with the provisions of the National Health Act.
(b) This question deals with the provisions of the National Health Act pertaining to the donation of gametes and the artificial fertilisation of Anna.

(i) The Act states that the gametes may only be removed or withdrawn if the person from whom the gametes are removed has given written consent on the prescribed form (s 55). See 8.3.2.1. The consent of both the donor and the recipient is governed by the regulations. See 8.3.2.3 and 8.3.2.12.

(ii) Dr Gene Joiner has certain responsibilities in respect of medical tests and examinations that must be performed. Note that Anna and Doris would have to undergo psychological evaluation since they know each other. See 8.3.2.5 and 8.3.2.14.

(c) Yes. See 8.3.4. Do not forget that the Children’s Act provides in section 303 that no person may artificially fertilise a woman in the execution of a surrogate motherhood agreement or render assistance in such artificial fertilisation, unless that artificial fertilisation is authorised by a court in terms of the provisions of this Act. See 8.4.12.

(d) Yes. The Children’s Act stipulates in section 292 that no surrogate motherhood agreement is valid unless the agreement is confirmed by the High Court. See 8.4.1. Section 293 provides that the court may not confirm the agreement unless the surrogate mother’s husband has given his written consent to the agreement and has become a party to the agreement. See 8.4.2.

(e) Yes. It appears from the wording of section 294 that surrogacy is possible where the commissioning parent is a single person. Where that is the case, that person’s gamete must be used. See 8.4.3.

(f) Section 296 stipulates that no artificial fertilisation of the surrogate mother may take place before the surrogate motherhood agreement is confirmed by the court. See 8.4.5. Moreover, section 303 expressly prohibits the artificial fertilisation of a woman in the execution of a surrogate motherhood agreement unless that artificial fertilisation is authorised by a court in terms of the provisions of the Act. If Dr Joiner contravenes this prohibition, she will be committing an offence (s 305(1)(b)) and will be liable, upon conviction, to a fine or to imprisonment for a period not exceeding ten years, or to both a fine and such imprisonment (s 305(6)). See 8.4.12.

(g) No. Note that only a surrogate mother who is also a genetic parent of the child concerned may terminate the surrogate motherhood agreement. Anna’s gametes are not going to be used for the artificial fertilisation. See 8.4.7.

(h) No. The regulations prohibit pre-implantation and prenatal testing for selecting the sex of a child except in the case of a serious sex-linked or sex-limited genetic condition (Reg 13). See 8.3.2.16.

(i) No. Only Anna has the right to decide to terminate the pregnancy. She must however inform Doris of her decision and consult with her. Remember that the provisions of the Choice on Termination of Pregnancy Act will apply. See 8.4.9.

GLOSSARY

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>abortion</td>
<td>Synonym for “termination of pregnancy”.</td>
</tr>
<tr>
<td>AF</td>
<td>Artificial fertilisation.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<td>-------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
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<tr>
<td>AID</td>
<td>See “artificial insemination, donor”. It is not regulated to the same degree as with AID.</td>
</tr>
<tr>
<td>AIH</td>
<td>See “artificial insemination, husband”. It is not regulated to the same degree as with AID.</td>
</tr>
<tr>
<td>artificial fertilisation</td>
<td>For purposes of the regulations governing artificial fertilisation – the introduction by other than natural means of a male gamete or gametes into the internal reproductive organs of a female person for the purpose of human reproduction. The following techniques are explicitly included within the definition of artificial fertilisation:</td>
</tr>
<tr>
<td></td>
<td>- artificial insemination</td>
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<td></td>
<td>- in vitro fertilisation</td>
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<td></td>
<td>- gamete intrafallopian transfer</td>
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<tr>
<td></td>
<td>- embryo intrafallopian transfer</td>
</tr>
<tr>
<td></td>
<td>- intracytoplasmic sperm injection</td>
</tr>
<tr>
<td></td>
<td>The listed techniques are also defined in the regulations, with the exception of gamete intrafallopian transfer and embryo intrafallopian transfer. See our definitions for these terms.</td>
</tr>
<tr>
<td>artificial insemination</td>
<td>For purposes of the regulations governing artificial fertilisation – the placing of male gametes (sperm) into the female reproductive tract by means other than copulation. Artificial insemination is a narrower concept than artificial fertilisation.</td>
</tr>
<tr>
<td>artificial insemination, donor</td>
<td>Artificial insemination of a woman by using semen from a donor (not her husband). Used where the woman’s husband is infertile. Also known as AID.</td>
</tr>
<tr>
<td>artificial insemination, husband</td>
<td>Artificial insemination of a woman with the husband’s semen. Also known as AIH. Used where there is an abnormality in the woman’s reproductive organs which prevents the husband’s seed to reach the ovum in the normal process of sexual relations.</td>
</tr>
<tr>
<td>commissioning parent(s)</td>
<td>For purposes of the Children’s Act 38 of 2005 – a person who enters into a surrogate motherhood agreement with a surrogate mother. “Commissioning father” has a corresponding meaning.</td>
</tr>
<tr>
<td>compelled rape</td>
<td>As defined in s 4 of The Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 – the unlawful and intentional forcing by A of a third person (C) without C’s consent, to commit an act of sexual penetration with a plaintiff (B) without B’s consent.</td>
</tr>
<tr>
<td>competent person</td>
<td>For purposes of the regulations governing artificial fertilisation – a person registered as such in terms of the Health Professions Act 56 of 1974. Only a medical practitioner specialising in gynaecology with training in reproductive medicine, or a medical scientist, medical technologist, clinical technologist with training in reproductive biology and related laboratory procedures qualifies to be competent person.</td>
</tr>
<tr>
<td><strong>donor file</strong></td>
<td>A file opened by a doctor planning to remove or aspirate a <strong>gamete</strong> for the purpose of <strong>artificial fertilisation</strong>, in which prescribed information has to be kept.</td>
</tr>
<tr>
<td><strong>embryo intrafallopian transfer</strong></td>
<td>Not defined in the regulations governing <strong>artificial fertilisation</strong>. This term is presumably used to refer to a procedure similar to <strong>gamete intrafallopian transfer</strong>, but where fertilisation of the egg occurs before the product (an embryo) is transferred into the woman’s Fallopian tube(s)).</td>
</tr>
<tr>
<td><strong>embryo transfer</strong></td>
<td>For purposes of the regulations governing <strong>artificial fertilisation</strong> – the placing of the embryo into the uterus or Fallopian tube of the recipient.</td>
</tr>
<tr>
<td><strong>eugenics</strong></td>
<td>The study and control of reproduction as a method of improving the hereditary characteristics of future generations of the human race. We differentiate between negative and positive eugenics. The first involves prevention of what is regarded as undesirable or inferior characteristics in humans by preventing reproduction of persons with such characteristics. The last involves promotion of optimal mating and reproduction of persons with characteristics regarded as superior.</td>
</tr>
<tr>
<td><strong>gamete</strong></td>
<td>Any one of the two sex cells needed for human reproduction, ie the male sperm and the female ovum.</td>
</tr>
<tr>
<td><strong>gamete intrafallopian transfer</strong></td>
<td>A procedure whereby semen and ova are mixed in vitro and immediately placed in the woman’s Fallopian tubes. Fertilisation thus occurs (other than with in vitro fertilisation) in the Fallopian tubes instead of in a petri dish. Abbreviation: GIFT. The possibility that fertilisation may occur before transfer cannot be excluded.</td>
</tr>
<tr>
<td><strong>intracytoplasmic sperm injection (ICSI)</strong></td>
<td>For purposes of the regulations governing <strong>artificial fertilisation</strong> – the process of microscopic technology to bring about fertilisation of an ovum with a male sperm outside the body in an authorised institution. This technique entails the injection of a single sperm into an egg with a very fine glass needle. If it results in fertilisation, the zygote is transferred to the woman’s uterus in the same way as in in vitro fertilisation. This technique is applied if a man’s sperm is unable to penetrate an egg, his sperm count is very low, or his sperm has poor motility. If a man’s semen (ejaculate) contains no sperm at all, sperm can sometimes be removed from his testes with a needle and used in ICSI.</td>
</tr>
<tr>
<td><strong>in vitro fertilisation</strong></td>
<td>For the purposes of the regulations governing artificial fertilisation - the process of spontaneous fertilisation of an ovum with a male sperm outside the body in an authorised institution. In in vitro fertilisation the woman whose eggs are to be used for the purposes of fertilisation receives hormonal treatment to stimulate her ovaries so that multiple eggs are produced. The eggs are then harvested and placed in a culture to allow them to mature further. The mature eggs are placed in a petri dish, and the semen of a donor or the woman’s husband is added. The fertilised eggs (zygotes) are then placed in the woman’s uterus.</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>mental disability</td>
<td>For the purposes of s 3(7) of the Sterilisation Act 44 of 1988 – scope of functioning ranging from partial self-care under strict supervision together with limited self-protection skills in a controlled environment with limited self-care, needing constant help and supervision, to limited sensory and motor functioning and needing nursing care. Sterilisation may within certain provisions in this section of the act be performed of a mentally disabled person without his/her consent.</td>
</tr>
<tr>
<td>rape</td>
<td>As defined in s 3 of The Criminal law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 – unlawful and intentional commission by A of an act of sexual penetration with a plaintiff (B), without B’s consent.</td>
</tr>
<tr>
<td>recipient file</td>
<td>File kept by doctor planning to perform artificial fertilisation on recipient, containing prescribed information as set out in the regulations.</td>
</tr>
<tr>
<td>semen analysis</td>
<td>Analysis of sperm entailing counting or estimating the number of sperm present in a fresh sample of ejaculate; evaluating the motility of the sperm; studying the morphology or build of the sperm. It is an important aid for determining infertility in men.</td>
</tr>
<tr>
<td>sexual penetration</td>
<td>Any act that causes penetration, in whatsoever degree, by means of (a) the sexual organs of a person into or past the sexual organs, anus, or mouth of someone else; or (b) any other part of the body of a person or any object, including any part of the body of an animal, into or past the sexual organs or anus of someone else.</td>
</tr>
<tr>
<td>statutory rape</td>
<td>As defined in s 15 of The Criminal law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 – committing an act of sexual penetration with a child (B) of 12 years or older, but younger than 16 years, in spite of B’s consent to the commission of the act. Also known as the crime of an act of consensual penetration of a child.</td>
</tr>
<tr>
<td>sterilisation</td>
<td>Procedure rendering a person permanently unable to be fertilised or procreate.</td>
</tr>
<tr>
<td>surrogate mother</td>
<td>An adult woman who enters into a surrogate motherhood agreement with the commissioning parent.</td>
</tr>
<tr>
<td>surrogate motherhood</td>
<td>See “surrogate motherhood agreement”.</td>
</tr>
<tr>
<td>surrogate motherhood agreement</td>
<td>An agreement between a surrogate mother and a commissioning parent in which it is agreed that the surrogate mother will be artificially fertilised for the purpose of bearing a child for the commissioning parent and in which the surrogate mother undertakes to hand over such a child to the commissioning parent upon its birth, or within a reasonable time thereafter, with the intention that the child concerned becomes the legitimate child of the commissioning parent.</td>
</tr>
<tr>
<td>termination of pregnancy</td>
<td>Separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman.</td>
</tr>
</tbody>
</table>
Criminal liability of the doctor

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9.2 Inquest
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9.7 Other offences
9.8 Relationship between criminal, delictual and disciplinary procedures

Learning Outcomes

When you have completed this study unit, you should be able to

- discuss the role of an inquest in the criminal prosecution of a doctor for culpable homicide or murder
9.1 Introduction

Medical negligence may result in the death of a patient, leading to the doctor being found guilty of culpable homicide. Fortunately this occurs relatively seldom in our country. In highly exceptional cases a doctor may even be found guilty of murder. As far as is known only one such case has been reported in South Africa. Today, however, the issue of “medical murder” has become relevant in connection with so-called “assisted suicide” which came to the fore in the modern euthanasia debate. (See our discussion in 6.2.3.1 above.) Although the emphasis in this study unit falls on medical doctors, the principles stated here apply equally to other health care workers. Where a physician by his unlawful conduct causes a patient’s death, he may be guilty either of murder or of culpable homicide.

In previous study units we have discussed matters of importance in respect of a charge of culpable homicide or murder. Here we will briefly examine further aspects in connection with culpable homicide and murder.

It may happen that a patient dies after medical treatment, and then the question is: What was the cause of his death?

9.2 Inquest

The Inquests Act 58 of 1959 governs all matters in connection with an inquest after the death of a person from a cause presumed to be other than a normal cause. In the context of medical malpractice this Act plays an important role in instituting criminal prosecution for culpable homicide or murder against a medical practitioner who caused the death of the patient in a negligent or intentional manner. The Act provides that any person who has reason to believe that any other person has died and that the death was due to other than natural causes, shall as soon as possible report accordingly to a policeman (s 2). As we saw in 3.11 above, the National Health Act 61 of 2003 provides (s 56) that the death of a patient whilst undergoing a procedure of therapeutic, diagnostic or palliative nature is not deemed to be a death from natural causes as contemplated by the Inquests Act 58 of 1959 or the Births and Deaths Registration Act 51 of 1992. The same applies where the death is the result of such procedure, or any aspect of such procedure is the primary cause of such death. This means that a post mortem has to be held before a doctor may issue a death certificate.

A policeman who has a reason to believe that any person has died from an unnatural cause has to investigate the circumstances of the death or cause it to be investigated, and report the death to a magistrate (s 3). If the body of the deceased is available, a post mortem must be held. The policeman must deliver a report to the public prosecutor (s 4). If criminal proceedings are not instituted in connection with the death, the public prosecutor shall submit the relevant information.
which he has obtained to the magistrate of the district concerned (s 5(1)). If on the information submitted to him or her it appears to the magistrate that a death has occurred and that such death was not due to natural causes, he or she shall ensure that an inquest as to the circumstances and cause of the death is held by a judicial officer with the necessary jurisdiction (s 5(2)). If the judicial officer undertaking the inquest should find that the death was caused by an act or omission that would prima facie amount to an offence on the part of any person, he or she shall submit or cause to be submitted the record of the proceedings to the Director of Public Prosecutions (s 17(1)(b)). The provisions of the Act do not prevent the institution of criminal proceedings against any person in connection with any death, whether or not an inquest has commenced in respect of such death (s 21).

9.3 Definitions of murder and culpable homicide

<table>
<thead>
<tr>
<th>Murder</th>
<th>Culpable homicide</th>
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<tbody>
<tr>
<td>Murder is the unlawful and <strong>intentional</strong> killing of another human being.</td>
<td>Culpable homicide is the unlawful and <strong>negligent</strong> killing of another human being.</td>
</tr>
</tbody>
</table>

Both crimes require conduct (an omissio or commissio) that is unlawful, causes the death of another, and is accompanied by fault. The fundamental difference between the two offences lies in the element of mens rea (fault). For murder intention is required; for culpable homicide negligence is required.

We saw that the doctor who had killed his father by injecting him with an overdose of morphine and pentothal was convicted of murder – *S v Hartmann* 1975 (3) SA 532 (K) (see 6.2.3.1 above). The conduct of a doctor who kills a patient with the motive of ending the patient’s suffering is unlawful, and the doctor’s motive is considered to be an extenuating circumstance. Therefore, active euthanasia amounts to murder because the doctor had the intention to end the patient’s life, even though the motive was to end the patient’s suffering.

The more problematic elements of criminal liability for the killing of a patient are causation and fault.

9.3.1 What is a human being?

The primary question concerning both these offences is whether a human being has been killed. From the physiological or medical point of view there seems to be no problem here. In law, however, there is a problem, since the answer to the question can be of great importance. The unlawful and intentional destruction of an incipient life, that is, of a foetus – illegal abortion, in contravention of the Choice of Termination of Pregnancy Act 92 of 1996, in other words – is a less serious offence than the intentional killing of a person who is already recognised as a human being, which would be murder. Practical administration of justice, therefore, requires a definite criterion in respect of the stage at which the foetus becomes a human being. A satisfactory substantive criterion has in South African law yet to be found. Section 239 of the Criminal Procedure Act 51 of 1977 contains a procedural provision (and applies a criterion which we shall call the “breathing test”):

At criminal proceedings at which an accused is charged with the killing of a newly-born child, such child shall be deemed to have been born alive if the child is proved to have breathed,
whether or not the child had an independent circulation, and it shall not be necessary to prove that such child was at the time of its death, entirely separated from the body of its mother.

As De Wet & Swanepoel 228 however rightly remarked, the breathing test fails to solve the problem of when a foetus ceases to be a foetus, and the question persists, furthermore, whether proof that the child did not breathe would of necessity lead to the conclusion that it had been stillborn.

The general method which is used in order to determine whether the child was breathing is to establish whether the lungs will float on water. From a medical point of view the respiration test is not altogether satisfactory, since it is an acknowledged fact today that the foetus, before birth, does in fact carry out positive respiratory movements, as the process distends the lungs so that, if they are subjected to a microscopic examination, they reveal a close similarity with the lungs of a newborn child who has breathed. Moreover, the possibility of respiration by the foetus in the womb is evidently not to be altogether excluded; see Williams (21–22), relying on Simpson K Modern trends in forensic medicine (1953).

To further complicate matters Gordon I, Shapiro SD and Berson HA Forensic medicine, a guide to principles 3 ed (1988) 379 et al (op cit) 379 mention “that cases have been recorded where respiratory movements were observed and infants were heard to cry although no portion of either lung would float”.

In S v Mshumpa 2008 (1) SASV 126 (E) the court had to decide on the question whether the definition of murder has to be extended to include the unlawful and intentional causing of the death of an unborn child. In this case the accused shot a woman who was in the last trimester of her pregnancy in her womb during a robbery. As a result of the gunshot wounds and in spite of emergency medical treatment, the foetus died. She was stillborn. As we have seen above, it has always been accepted that murder can only be committed in respect of a child who was born alive. Moreover, the killing of an unborn child was at the time of the proceedings in court also not acknowledged as some other offence. The principle of legality prevents an accused to be found guilty of an offence if his or her actions were not acknowledged as an offence at the time when these were committed. Furthermore, the court declared that the legislator is the relevant authority to extend the definition if it should indeed be extended. The accused were found not guilty of murder.

9.4 Causation

In both crimes – murder and culpable homicide – it is necessary to prove a causal connection between the act of the perpetrator and the death of the victim. The perpetrator need not have applied violence directly to the body of the deceased; to have brought about death indirectly, for example by acquiring the services of someone else to take with the victim, is sufficient. Even the pre-natal injuring of a foetus by, for example, assaulting the mother, may, if the child dies after birth, make the perpetrator liable to conviction of either murder or culpable homicide.

Causation entails both factual and legal causation. To answer the question whether there is factual causation, the conditio sine qua non test (the “but for” test) is applied. The act of the perpetrator is “thought away”, and if the harmful result – in this case the death – then also disappears, the perpetrator was the factual cause thereof. For legal causation a number of tests or theories may be applied. These are discussed in detail in the module for criminal law.
In brief they are the following:

- **The theory of adequate causation**: An act is deemed to be the legal cause of a specific result if, according to human experience, in the normal course of events such a type of act generally has the tendency to bring about that particular type of result.

- **Novus actus interveniens**: An act is a *novus actus interveniens* if it is an unexpected, abnormal or unusual occurrence which, according to general human experience, deviates from the normal run of events. Such an act breaks the chain of causation between the original act and the ultimate result, leading to the conclusion that the original act which qualifies as a factual cause of the result cannot also be said to be a legal cause of the result. In the eyes of the law there is therefore no causation.

- **Individualisation theory** – According to this theory one has to consider all the factors which qualify as factual causes of the result (the death of the victim), and then search for one single factor which can be said to be the most important one. Such factor is then singled out and regarded as the legal cause of the result.

### 9.4.1 Doctor in good faith supplies medicine to patient, who dies

A pertinent question is prompted here: If a physician merely supplies a patient with drugs or other potentially harmful substances, as a result of which the patient dies, can the physician be convicted of murder or culpable homicide? The administering of the medicine by the physician himself creates no problems, but here we are concerned with the act of supplying the medicine, in contradistinction to the act of administering it – a problem that has already been posed in connection with euthanasia.

In answering this question the usual test for causation must be applied, namely whether, in accordance with the *dicta* of our courts, the death of the deceased is a reasonable and probable consequence of the perpetrator's conduct, and not the result of a new, independent or intervening occurrence (*novus actus interveniens*). If the medicine were made available in circumstances where the death of the receiver was not a likely consequence of such availability, then we accept that the existence of a causal connection will not readily be recognised by the courts. This would apply where, for example, the doctor in good faith gives a patient who complains of insomnia some sleeping tablets. There is no sign of serious depression in the patient, and he also does not complain of it. Instead of taking a single tablet at bedtime, as prescribed, the patient takes all the tablets at once with the intention to take his own life.

It is unlikely that a court would find the doctor's conduct to have been the legal cause of death in these circumstances. Moreover, it would be very difficult to find any *fault* (intention or negligence) on the part of the doctor.

### 9.4.2 Doctor supplies harmful substance to a patient in circumstances where death would be a likely consequence

However, the situation is totally different if the physician makes the harmful medicine available in circumstances which would make death a likely consequence, for example if the patient requests it expressly in order to commit suicide, or if the doctor encourages the patient to use it to commit suicide, or if the physician knows that it is potentially highly dangerous, but the patient thinks it is harmless.

In cases such as these the existence of a causal connection ought, in our opinion, to be accepted, and the liability of the practitioner ought to depend on his *fault* or *mens rea*, which, in the
circumstances quoted, may justify the inference of an intention to kill, or at the very least, negligence. Therefore, if the doctor foresaw that the patient might use the substance to commit suicide, and reconciled himself to such a possibility, the doctor may be guilty of murder. If the doctor did not foresee the suicide, or did not reconcile himself with such a possibility, but the reasonable person in his position would have foreseen it and would have taken steps to guard against such an occurrence, the doctor may be liable for culpable homicide.

In 2011 the pop idol Michael Jackson’s doctor was found guilty in Los Angeles of so-called involuntary manslaughter because he supplied Jackson, who suffered from insomnia, with propofol. Jackson died as result of an overdose of this substance. Propofol is a strong drug which is also used as anaesthetic, and should only be given by specialists in a medical set-up, because it suppresses breathing, may slow down heartbeat and lower blood pressure.

The argument that the deceased would in any case have acquired the fatal substance elsewhere had the accused not made it available to him, is, of course, without substance. The existence of a causal connection is not dependent upon other hypothetical causes, and speculation of this kind is not legally relevant.

It is likewise inadmissible to argue that since suicide is not a crime in our law (see R v Peverett 1940 AD 213) it is not unlawful to assist a person to commit suicide. Joint causation of the death of another (in the absence of a ground of justification) is always unlawful. There is, from a socio-ethical point of view, a significant difference between an act intended to terminate one’s own existence, and an act intended to terminate the existence of another. In the latter there is a positive disregard for the interests of another. (There are other conceivable circumstances in which negligence is present, for example where a physician makes poison available, thinking it to be harmless; here, the physician may at least be found guilty of culpable homicide.) There are, however, indications in our case law which show that the supplying of a harmful substance to an intended suicide (the situation first quoted) is not punishable as murder or culpable homicide.

Take the case of S v Gordon 1962 (4) SA 727 (N), where, in the following factual situation, the accused was acquitted on a charge of murder: The accused and his mistress had entered into a so-called “suicide pact”. The accused gave the woman drugs (15 Noludar tablets, and 8 Phanodorm tablets). She took the tablets and subsequently died. Her act (in taking the tablets) was, according to the court, a novus actus interveniens; the conduct of the accused was not the cause of her death.

In R v Matthews 1950 (3) SA 671 (N), on the other hand, the accused, in somewhat different circumstances, was found guilty of culpable homicide. The accused, in this case, supplied the deceased, who was already under the influence of liquor, with three glasses of sherry, and persuaded him to drink them in quick succession. As a result of this the deceased died. The accused, who was the employer of the deceased, exercised, according to the court, a certain degree of authority over him, and the conduct of the accused did in fact constitute the administering of the alcohol. It is clearly shown by Matthews that persuasion or encouragement to imbibe a harmful substance can in fact constitute the necessary causal connection.

The decision in Gordon was, in our respectful opinion, open to criticism, and the perpetrator, as we have said above, should have been found guilty of murder, or at least of culpable homicide. (See Strauss SA 1963 THRHR 57.) It is in any case almost inconceivable that a court, in circumstances
where a physician was the provider, would arrive at the same conclusion, since a physician, by
virtue of his profession, finds himself in a position of trust.

_Gordon_ cannot be considered authoritative any longer, in view of the decision of the Appellate
Division in _S v Grotjohn_ 1970 (2) SA 355 (A), supporting the view that a person who assists another
in committing suicide may in certain circumstances be guilty of _murder_ or _culpable homicide_. In this
case the Appellate Division made it clear that if a person (X) supplies another (Y) with the means to
commit suicide, the mere fact that the last act causing Y’s death (the act of suicide) is Y’s own
voluntary, non-criminal act does not necessarily break the chain of causation set in motion by X. It
may be added that in the latter case the furnishing of a firearm was at issue, not the supplying of
drugs. However, in principle there is no difference.

The legal issues involved in a doctor's assisting a severely suffering patient with a terminal illness
who wishes to end his own life, have drawn worldwide attention in consequence of the actions of a
Dr Jack Kevorkian in Michigan USA during the 1990s. Kevorkian, a vehement protagonist of
“planned death” – and dubbed by the media “Dr Death” – developed an apparatus which could be
connected to the patient by way of an intravenous needle. If the patient pushed a button, an
anaesthetic substance would be fed by the apparatus into his bloodstream, followed by potassium
chloride which would result in cardiac arrest within minutes.

During the 1990s the legislature of the Australian Northern Territories state enacted legislation to
legalise doctor-assisted suicide for a severely suffering patient within certain narrow limitations. A
few cases were publicised, but the Australian federal parliament soon stepped in and nullified the
state legislation.

In the late 1990s the SA Law Commission made certain recommendations concerning passive
euthanasia which would also have included legislation on what may be termed doctor-assisted
suicide within the limits set by the Commission. So far nothing has come of these recommendations.
The Commission’s final report was tabled in Parliament at the beginning of 2000.

Doctor-assisted suicide remains a highly controversial issue in most societies, but it is said that it
has become a fairly general practice in, for instance, the Netherlands. In 2001 the Dutch parliament
passed an Act which declares doctor-assisted suicide in extreme cases lawful. The requirements
are very strict. _Inter alia_ the doctor must be satisfied that the patient’s suffering is unbearable and
that there is no prospect of improvement. Such cases must afterwards be officially reported and will
then be assessed by a review committee. Other countries that have legalised assisted suicide within
limits are Belgium and Switzerland.

### 9.5 Negligence

#### 9.5.1 The criterion for establishing negligence

Negligence as a form of _fault_ is the blame that attaches to an attitude or conduct attesting of
carelessness, thoughtlessness or imprudence. A person is negligent if he or she fails to live up to
the standard of care required by law.

The general criterion for negligence is that of the reasonable person. This criterion is one of
objective reasonableness. Since in medical law we are dealing with the liability of health care
providers who are responsible for upholding certain professional standards, applying the reasonable
person criterion would not do. It would not make sense to measure the conduct of a brain surgeon performing an exquisitely delicate operation against that of the reasonable person, for the reasonable person knows absolutely nothing about brain surgery. A measure of subjectivity must be incorporated with the criterion for determining negligence: The reasonable person must be invested with the knowledge, competence, skill and care possessed and exercised by the ordinary health care practitioner belonging to the specific branch of the health care profession concerned. Where the negligence of a general practitioner is concerned, the criterion is that of the reasonable general practitioner, where the negligence of a gastroenterologist is concerned, the criterion is that of the reasonable gastroenterologist, and where the negligence of a theatre sister is concerned, the criterion is that of the reasonable theatre sister.

The criterion applied in determining negligence for the purposes of criminal liability is the same as that applied when enquiring into negligence for the purposes of delictual liability (which we discuss in study unit 10).

9.5.2 The test for negligence when dealing with a charge of culpable homicide

We now know what the criterion for establishing negligence is. The enquiry into negligence always concerns the question whether the reasonable person would have foreseen a certain result and would have prevented it. The test for negligence involves the question whether the person whose negligence has to be determined fell short of the criterion in respect of the causing of the result concerned.

Where the charge is culpable homicide, the question to be determined is whether the health care provider was negligent in respect of the particular result, namely the death of the patient. The test for negligence for purposes of culpable homicide can be defined as follows:

A health care practitioner is negligent in respect of the death of a patient if the reasonable health care practitioner belonging to his or her particular branch of the health care profession concerned

- would have foreseen the possibility that his or her conduct could lead to the patient’s death, and
- would have taken steps to prevent the patient’s death
- but the health care practitioner concerned failed to take such steps.

9.5.3 The degree of negligence required for a conviction of culpable homicide

Distinguishing between ordinary negligence and gross negligence is of little consequence in our law. Barlow TB 1948 THRHR 173 at 190 suggested that a physician should be prosecuted for having caused a person’s death through negligence only in cases of gross negligence (“where one feels a sense of shock”) and not in cases where the physician’s negligence was slight (“mistakes which may be little more than a slip”). In R v Van der Merwe 1953 (2) PH H124 (W) (fully reported as R v T v d M in 1953 Journal of Forensic Medicine 68) an English case was used as support when
arguing on behalf of a physician who was charged with culpable homicide, namely that a person cannot be convicted of criminal negligence unless his negligence was of a gross nature. The court, however, per Roper J rejected this view:

It is not our law; the basis of our law in this country is the Roman-Dutch Law, and it is not part of our law that a person, whether professional or not, can only be found guilty criminally if he is guilty of gross negligence. In our law the test of negligence is exactly the same in civil as in criminal case ... . In our law a man is liable criminally for negligence whether his negligence is gross or slight.

However, Carstens argues that the degree of negligence will indeed play a role when considering the sentence, but concedes that the degree of criminal liability is a concept particular to English law (see Carstens PA 2006 SACJ 192 at 202–203).

9.5.4 Imperitia culpae adnumeratur ("ignorance or lack of skill is deemed to be negligence")

Dr Kotsi Monang, a young and inexperienced general practitioner, is worried. He ponders his position. Everything is going well in his practice: there are people who are very ill; there is the boring but steady stream of flu cases; there are the hypochondriacs, and there are those whose excuses to get a sick certificate are as weak as the hospital tea. He has no reason to complain and there is also nothing to get very excited about. He would like to extend his practice, but does not know how. He looks at his competitors: they are all successful. There is the cause of his annoyance, the Joneses. Both are doctors and thus have a double income. He cannot keep up with them. Then there is also the old man, Dr Oupa Botlhale, famous plastic surgeon with years’ experience. Kotsi knows an opportunity when he sees one. He reckons success lies in grabbing a chance if it comes your way. It is ironic that this chance should come at one of the Jones's parties. Larger than life: people who believe that you can never be too rich or too thin. Over his cocktail he would hear the same refrain: I am too fat. There and then he decides in which direction to branch out: plastic surgery. He reads up a bit, and before long he performs liposuctions. Dr Botlhale’s warnings that one should not underestimate liposuctions fall on deaf ears. Soon there is a charge of culpable homicide against Kotsi after Betty Bam, a patient on whom he performed liposuction, suffered many complications, among them a lung embolus (blood clot). Kotsi, through lack of experience and proper training, missed the danger signs, and Ms Bam died. This story entails imperitia culpae adnumeratur.

Imperitia culpae adnumeratur literally means that lack of knowledge, skill or competence will be reckoned as fault. The literal translation is however somewhat misleading. It is not the lack of knowledge, skill or competence as such that is reckoned as fault. Imperitia culpae adnumeratur finds application where the doctor undertakes a certain activity that calls for expertise, experience or expert skill while not in possession of those. A person will be found negligent under such circumstances on the strength of the application of imperitia culpae adnumeratur only if he or she was aware or should reasonably have been aware that he or she did not have the necessary
knowledge, skill or competence to give the particular advice or to perform the particular intervention, and the patient died as a result thereof. A medical practitioner who possesses insufficient knowledge, skill or competence to embark upon a particular area of practice, exposes himself or herself to liability on account of negligence. A good example from case law is *S v Mkwetshana* which we discuss in 9.6.1: When reading our discussion of that case, study the quotations from the judgment.

9.5.5 Negligence is judged in the light of the surrounding circumstances

Negligence is judged in the light of all relevant surrounding circumstances. The test remains whether the accused acted like the reasonable person. The following considerations in respect of the surrounding circumstances often crop up in the medical context (see Neethling J, Potgieter JM & Visser PJ *Law of delict* 5 ed (2006) 133–136):

9.5.5.1 Inherently dangerous substances, ‘devices’ or conditions

It has been pointed out that a person who accepts control of a dangerous object is obliged to exercise proper control over it (5.6.2.2), and that a person who creates a potentially dangerous situation is obliged to avert the harm (5.6.2.1). The inherently dangerous nature of a substance, device or condition must also be taken into consideration when enquiring into the question whether there was any negligence on the part of the health care provider. Negligence concerns the level of care and skill required by law. Greater care is required when one is working with an inherently dangerous substance or device, or when one creates an inherently dangerous
situation or accepts control over such a situation. The birth of a child is an inherently dangerous situation and the potential for complications is great. Certain substances prescribed or administered by doctors are inherently dangerous. A patient is not admitted to an intensive care unit without good reason. Of course, the reasonable health care provider is aware of all the dangers associated with his or her particular branch of the health care profession. A doctor who administers a substance that contains arsenic should exercise greater care than is expected from one who administers a harmless substance. See for example R v Van Schoor and S v Mkwenkwe which are discussed in 9.6.1.

9.5.5.2 Doctrine of sudden emergency
The same level of skill and judgment cannot be expected of a person who faces a sudden emergency than can be expected of a person who does not face such a situation. The law recognises that a person facing a sudden emergency does not have the same opportunity to weigh all his or her options carefully. This principle is sometimes referred to as the “doctrine of sudden emergency”. Strictly speaking this is no doctrine, but merely an acknowledgment that the reasonable medical practitioner can also make an error of judgment and may even act somewhat peculiarly if facing an imminent peril. Completely irrational behaviour will obviously not be excused. S v Kramer, which we discuss in 9.6.3, serves as a good example. An operation is performed by a team of health care professionals, each having his or her own task to fulfil. Normally, a surgeon is not responsible for managing the patient’s anaesthesia. In S v Kramer the surgeon suddenly found himself in an extreme emergency when it appeared that the patient was cyanosed and the anaesthetist had “frozen” under the circumstances. He was faced with two problems: the patient was not receiving sufficient oxygen and there were signs that she was coming to. Furthermore, he had to prevent her from aspirating blood into her lungs. He first finished removing the left tonsil, sucked away the blood in her throat, and, with the aid of a laryngoscope established that the tube was not in the patient’s trachea. He decided to re-intubate the patient with a different tube in order to establish an airway for administering both oxygen and anaesthetic gasses. A muscle relaxant such as scolene is usually administered to relax the patient’s muscles so as to allow the tube to be inserted. The surgeon therefore ordered the anaesthetist to administer another dose of scolene. The surgeon was later blamed by the court a quo for ordering the administering of a further dose of scolene as this would have caused the patient’s lungs to be paralysed and normal breathing to be hampered. On appeal the Supreme Court takes into consideration the fact that the surgeon found himself in a situation of extreme emergency and comes to the conclusion that, even if it could be said that some other measure could have been taken to establish an airway without administering a further dose of scolene, the surgeon could not be found to have been at fault for the way in which he acted under the circumstances. He acted swiftly when the emergency arose and took all reasonable measures to resuscitate the patient.

9.5.5.3 The patient suffers from some incapacity/defect/allergy
Greater care is required when the patient suffers from some incapacity or defect that predisposes him or her to accidents, complications or other adverse events. Take for example an aged patient suffering from dementia who has just come to after an operation. It would be negligent to allow the patient to lie in a bed without any safety railings. A doctor must proceed with caution when prescribing certain substances to a patient suffering from renal insufficiency or some serious liver ailment. A doctor also has to enquire with the necessary care about any allergies the patient might
be suffering from in order to avoid administering a substance to which the patient is allergic. We referred earlier to the seriously depressed patient with suicidal tendencies and the need to proceed with caution when supplying such a patient with dangerous medication. Nursing staff should be extra careful to avoid pressure sores in an immobile patient.

9.5.5.4 Statutory provisions indicating negligence

Although the court is ultimately to judge the reasonableness or otherwise of the medical practitioner’s conduct, the existence of a statutory provision may sometimes be indicative or afford proof of negligence. Where a competent person effects artificial fertilisation and the recipient is fertilised with semen infected with a sexually transmissible disease, the competent person may incur criminal liability if the patient or the child should die as a result of the infection. (Of course, a competent person may also incur delictual liability for any damage caused as a result of the infection, even when it does not lead to death.) A clear indication of negligence is to be found in the provision in the regulations which states that the competent person is responsible for ascertaining that certain medical tests for sexually transmissible diseases have been performed on the donor (see 8.3.2.5). Should the competent person fail to do so, it would afford proof of negligence. Another example is the case where a medical practitioner performs an abortion at a place that does not have appropriate infection control measures, the patient develops sepsis and dies (see 8.2.7).

9.6 Examples from case law

In South Africa physicians have, in various cases, been found guilty of culpable homicide. We briefly discuss some of these cases. They bring important principles to the fore, and practical guidelines for doctors may be found in the judgments. In your study of these cases you should concentrate on the essential facts and principles, and the reasons advanced for the judgments.

9.6.1 Overdose of medicine

*R v Van Schoor* 1948 (4) SA 349 (C): Dr Van Schoor, a young doctor, joined Dr R as his assistant. Seven days later Dr E, another assistant of Dr R, had to treat a number of syphilis patients. Dr E was busy, however, and he requested Dr Van Schoor to carry out the treatment, the injection of a new serum, *Neo-Halarsine*, which contained arsenic. Dr Van Schoor had little or no experience of the substance.

When Dr E asked Dr Van Schoor to treat the patients, Dr Van Schoor apparently asked Dr E what he ought to do. Dr E failed to realise that Dr Van Schoor knew nothing about the drug, and he merely pointed to a shelf where it was stored with other medicines, and told him to “take an ampoule, mix it with 9 cc of water, and that is the maximum dose”. Dr E was under the impression that the ampoules contained 0.09 grams. Other cartons had, however, been placed on the shelf without his knowledge, and each ampoule in these cartons contained ten times this amount. On the outside of each dose appeared a description of the mixture and the dose contained in the ampoule; each box contained instructions on how to use the mixture. Dr Van Schoor did not read the instructions, and administered, by intravenous injection, the contents of each ampoule to all the patients. Two of the patients died as a result of the overdose. The court ruled that Dr Van Schoor had been negligent, and found him guilty of culpable homicide.
R v Van der Merwe 1953 (2) PH H124 (W): The accused, a general practitioner, was consulted by a seventy-year-old woman. She gave a history of an old “white leg” on her left side, and of a femoral thrombosis she had had a short time before, and which, apparently, had not yet cleared up. An examination by the physician revealed that active thrombosis was still present.

The doctor decided to treat her condition with Dicumarol, and supplied her with the following prescription: “Mrs ... Dicumarol, 40 tabs One t.d.s.p.c.”. The pharmacist who received the prescription from the patient was unable to contact the physician; he consulted the British Pharmacopoeia, and gave the patient 40 tablets of 100 mg strength. The patient consumed 38 tablets (3 800 mg) in a period of 13 days. The first indications of bleeding became noticeable eight days after she had begun taking the tablets. Three days later her gums and a sore between her shoulders began to bleed. Two days later the doctor was informed of her condition by telephone. He instructed her to stop using the tablets, but did not visit her or prescribe any other treatment.

Her condition continued to deteriorate, with bleeding from the mouth and bladder, and other grave symptoms. The patient’s husband informed the physician of the symptoms, and the physician gave instructions for the administering of Vitamin K. There was no improvement, and, since the physician was not available, his colleague was summoned. He had the patient removed to a nursing home. In spite of blood transfusions and Vitamin K injections, the patient died shortly afterwards. The doctor was charged with culpable homicide, and the prosecution alleged seven grounds of negligence.

Inter alia it was alleged that he had failed, before administering and prescribing the medicine, to acquaint himself with the strength and dosage in which it ought to have been prescribed.

On behalf of the doctor it was argued that when he wrote the prescription he had a dosage of 25 mg in mind, which was to have been administered three times a day (which, according to medical evidence, would have been harmless). It was also submitted that a doctor is entitled to expect a pharmacist to telephone him if he (the doctor) has failed to mention the dosage. On this point the judge, in his summary, declared the following to the jury:

I must say that to me it appears to be a very alarming suggestion, that a doctor who is supposed to have superior knowledge should be entitled, if he issues a faulty prescription, to shelter himself behind the chemist who makes it up. You must ask yourself whether it is not his duty to issue a prescription in such a form that the chemist will not make a mistake.

The jury found the doctor guilty.

S v Mkwetshana 1965 (2) SA 493 (N): The accused was a young qualified doctor who was doing his internship at a hospital for twelve months. One of the female patients was suffering from bronchial asthma. She received treatment and when her condition improved, was discharged. There were, however, certain problems in connection with her return home since she stayed far away, and therefore she remained in hospital over the Easter week-end. On Good Friday morning a staff nurse noticed that the patient was restless and was finding it difficult to breathe.

The only medical officer available in the hospital (or in the particular section of the hospital) at the time was the accused. When he arrived at the patient’s bedside she was kicking convulsively, waving her arms. Her lips and tongue had a blue tinge and she was foaming at the mouth. The accused diagnosed a serious form of acute asthma. He ordered 20 cc of amenophylline – a
recognised drug for the treatment of asthma – and administered it intravenously. After five or seven minutes there was no improvement.

Then it occurred to the accused that the attack might be epilepsy, and he decided to try paraldehyde. He administered 20 cc of the drug intravenously. The patient’s condition improved and he left her. However, she died a quarter of an hour later; it appeared that 20 cc of the latter drug was an overdose. The recognised intravenous dosage, according to scientific evidence, should not have exceeded 5 cc; even then, it should have been diluted with a solution of sodium chloride in the proportion of one to ten.

The accused was found guilty on a charge of culpable homicide. On appeal it was argued, inter alia, that, since he was an intern, comparatively inexperienced, and confronted with an emergency, he could not be charged with negligence; he did his very best, it was submitted, in the emergency: he could not have been expected to remember the safe dosage, as laid down, and he did not have an opportunity to consult textbooks, or to appeal to his seniors.

The court of appeal rejected this contention, however, and Caney J held as follows (at 497):

\[
\text{Either the appellant had insufficient knowledge and experience of the drug, in which case it was negligence on his part to administer it in the manner in which he did administer it; if he knew little, if anything, about it he was subjecting his patient to a very considerable risk ... for him to have done that, in the light of his inexperience, and particularly his inexperience of this drug and its uses, marks him as having been negligent.}
\]

The judge pointed out that information on the use of the drug in question was freely available, both in medical textbooks used by students and elsewhere. He continued:

\[
\text{There can be no excuse for a medical man, even though just setting out on his career, if he neither knows these doses and uses, nor troubles to have them available to him.}
\]

In the circumstances, the judge held, that the accused should have contacted one of his seniors, even telephonically, or he should have obtained assistance from one of the staff nurses. The conviction was therefore confirmed.

9.6.2 Failure of general practitioner to call in specialist

In our discussion of the contract between doctor and patient (4.1.1.4 above), we pointed out that if the diagnosis or treatment falls beyond the doctor’s training sphere or specialist field, the doctor is obliged to refer the patient to a suitable expert or to call in such person’s help. Here we discuss a case where a doctor was convicted of culpable homicide inter alia because of his failure to call in a specialist.

In *S v Nel* 1988 (1) *SA Practice Management* 7 Dr Nel, a general practitioner, was attending to a woman when she gave delivery to her third child. Immediately after the birth of the child Dr Nel experienced problems with the removal of the placenta (afterbirth) from her uterus. The patient bled profusely and died later the same evening from loss of blood and shock.

It appeared that the patient had been admitted to a maternity home at about 11:45 that day for her confinement. By 17:45 the doctor was called to the maternity home. He regarded it as necessary for the purposes of the confinement to conduct surgery, and carried out a left lateral episiotomy (a cut
through the labia). The baby was delivered at 18:45. Complications set in, however, in that the placenta remained behind in the uterus. Dr Nel tried by application of the Brandt-Andrews technique to deliver the placenta, but had no success. He proceeded to make several attempts to remove the placenta by hand, but these were also in vain.

The patient's husband, H, was present, and observed that the doctor was apparently experiencing serious problems and that in the meantime his wife was suffering tremendously. Later H testified in court that shortly after the birth of the child Dr Nel had pushed his hand into the patient's vagina and pulled on the umbilical cord so that it broke and blood splashed all over a nursing sister. A heated argument between the doctor and the sister followed. Thereupon the doctor twice inserted his hand into the patient's vagina up to his elbow and kept it there on each occasion for approximately 30 seconds.

All Dr Nel's attempts to remove the placenta were to no avail, and by 19:00 Dr Nel left the maternity ward. Mr H learnt from the matron that there was a specialist on the premises. H came across Dr Nel outside the maternity ward and told him of the specialist. Dr Nel's reaction, however, was to tell H that he was “not a monkey” and that he would call in a specialist should he be in need of one.

Between 19:00 and 19:20 H was informed by Dr Nel that he had called in an anaesthetist. The anaesthetist arrived at 19:40 and noticed that there had already been a massive loss of blood. He established that no blood specimen had been taken, that no blood plasma had been ordered, and that no intravenous infusion of fluid had been started.

The anaesthetist immediately took the patient's blood pressure, commenced an intravenous infusion and administered anaesthesia by means of pentothal (sodium thiopentone). Only at this stage did Dr Nel at the request of the matron agree to call in a specialist, Dr S, with the remark that "a second opinion would do no harm". To the knowledge of Dr Nel, Dr S had already been in the maternity home since about 19:00 and had been available, should Dr Nel have required his assistance.

Accordingly it was only at a relatively late stage, at 20:10, that Dr S arrived in the maternity ward and started attending to the patient. He removed the placenta tissue easily by hand, and began to suture the episiotomy incision which had remained unsutured up to that stage. Before he could complete this, the patient died, at 20:20.

Dr Nel was charged in the regional court with culpable homicide. The court found that he had been negligent in respect of several respects. Amongst other things he had failed to take proper blood-pressure measurements, to do a necessary intravenous infusion before endeavouring to remove the placenta by hand, to take a blood specimen and to order blood, to call in a specialist obstetrician in spite of a request to that effect made by the patient’s husband, and to rub the uterus in order to let it contract. He had made unsuccessful and unskilful attempts to remove the placenta whilst valuable anaesthetic time had been lost, and he had left the maternity ward at a critical time. The court held that the accused's negligence had been the cause of the patient's death.

On appeal to the Transvaal Provincial Division of the Supreme Court it was contended that it had not been proved beyond reasonable doubt that an omission on the part of Dr Nel had been the cause of the patient’s death. A specialist anaesthetist had testified during the trial that the administration of pentothal and halothane by the anaesthetist could have caused the patient’s death. However, the court rejected this argument with the following comment: “This sort of wide statement is not of real
value. Anything can happen. One sometimes reads that the taking of aspirin can cause death. That does not say a thing” (our translation).

What the witness ought to have done, according to Eloff J, if he had wanted to make an objective scientific contribution to the court’s task, was to explain how real the possibility had been that administration of these substances could have caused death. It is difficult to avoid the impression, the judge observed, that the expert witness “simply took a shot in the dark” to try and help the accused. The court accordingly confirmed the magistrate’s verdict.

However, the High Court held that the sentence imposed by the regional court – five years’ imprisonment, of which three years were conditionally suspended – was excessively heavy. The accused’s failure to call in a specialist was no more than a reprehensible error of judgment, and did not constitute recklessness. The facts of the case pointed rather to clumsiness and a lack of skill. A sentence of a fine of R5 000 with the alternative of a sentence of two years’ imprisonment coupled with a suspended sentence of two years was accordingly substituted.

The Appeal Court subsequently refused to grant the doctor leave to appeal.

9.6.3 Incorrect procedure during anaesthesia

In *S v Kramer* 1987 (1) SA 887 (W) a relatively inexperienced anaesthetist, worked with a surgeon during a tonsillectomy and adenoidectomy performed on a ten year old girl. The anaesthetist anaesthetised the patient and the surgeon asked, and was given, permission to proceed with the operation. The surgeon then started to remove the left tonsil. The anaesthetist had failed to insert an endotracheal tube correctly. The patient became cyanosed and the surgeon noticed this. He continued to remove the left tonsil and then, with the aid of a laryngoscope, came to the conclusion that the tube was not in the trachea (windpipe). He immediately ordered further doses of fabantol and scolene (drugs used in connection with anaesthesia), removed the tube and reintubated the patient with another tube. The patient was ventilated and her colour improved. She suddenly became cyanosed again and as no pulse was palpable, cardiac massage was started. Attempts were made to stimulate the patient’s heart with a defibrillator (an apparatus that delivers an electric shock) but to no avail. The patient died in the theatre.

In the magistrate’s court both the surgeon and the anaesthetist were convicted of culpable homicide. The surgeon was found to have been negligent in that he

- should have ensured that the endotracheal tube had been correctly inserted by the anaesthetist – the court *a quo* found that this duty on the surgeon arose as a result of the following:
  - he knew that the anaesthetist was a relatively inexperienced anaesthetist
  - he knew that every anaesthetist can place an endotracheal tube wrongly
  - he admitted at the inquest that had he checked if the tube had been correctly placed, the deceased’s death could have been avoided

- should not have removed the left tonsil after he had seen that the patient had become cyanosed – in doing so he delayed commencing the resuscitative measures
- should not have ordered the anaesthetist to inject more scolene, a drug that would paralyse the lungs of the patient and prevent her from breathing normally
Endotracheal intubation vs esophageal intubation

The court *a quo* found the anaesthetist to have been negligent in that he

- should not have relied on the sister to choose an appropriate length of endotracheal tube, as it was possible that the tube which was inserted was too short or that it was not inserted deep enough into the trachea
- did not insert the tube into the trachea at all
- did not monitor the patient’s condition adequately and therefore did not timeously detect that the supply of oxygen to the patient’s lungs was inadequate
- should not have frozen at the first signs of a crisis, as he was busy with a dangerous undertaking and the patient’s life was in his hands

The Court of Appeal held that in general neither the surgeon nor the anaesthetist is liable for the other’s negligence. This general rule will, however, be subject to exceptions, for example where the surgeon knew that the anaesthetist was incompetent or not in a fit condition to perform his duties. There may also be other exceptions. The court was of the opinion that there was no duty on the surgeon to have looked down the trachea of the patient to check the position of the tube before commencing the operation. The court rejected the court *a quo*’s conclusion that the surgeon should not first have completed removing the left tonsil before commencing resuscitative measures. The half-cut tonsil was bleeding profusely into the very area of the deceased’s throat into which somebody had to look to see whether or not the tube had been correctly placed. The court found that the magistrate was wrong in finding that the surgeon was at fault to have ordered the
anaesthetist to inject more scolene. In order to insert a new tube, a muscle relaxant (such as scolene) was necessary. The court came to the conclusion that the surgeon, when faced with the extreme emergency, had acted swiftly and reasonably in trying to create an airway, and took all reasonable measures to resuscitate the deceased under the prevailing circumstances.

The Court held that the anaesthetist had been negligent in failing to insert the tube correctly and in failing to monitor the patient properly, by which the misplacement of the tube could have been discovered.

9.6.4 Radiology: excessive amount of contrast medium

In S v Bezuidenhout 1987 (1) SA Practice Management 27 (A) the accused, Dr Bezuidenhout, a radiologist, performed a radiological examination on a six-week-old baby boy for a urological problem. An intravenous contrast medium, Urografin, was administered and a number of X-rays taken. Shortly afterwards the child developed convulsions that would not cease. He was treated in the children’s ward of the hospital and was later transferred to an intensive care unit where he died five days later.

Dr Bezuidenhout and the radiographer who assisted him were charged with culpable homicide in the regional court, and convicted. The magistrate found that the cause of the convulsions and subsequent death had been an overdose of contrast medium, administered negligently by the accused. Upon appeal to the Supreme Court the radiographer’s conviction was set aside but that of Dr Bezuidenhout confirmed. Dr Bezuidenhout appealed to the Appellate Division.

In the Appellate Division it was argued on behalf of Dr Bezuidenhout, on the basis of the evidence of one of the expert witnesses that the convulsions could have been due to either of the following:

(1) an overdose  
(2) hypersensitivity for the contrast medium used  
(3) a congenital tendency of the child to develop epilepsy

It was contended that in respect of the latter two possibilities even a normal dosage of the contrast medium could have resulted in convulsions.

The Court found that it had been proved that about 125 ml of the contrast medium had been administered to the child, a quantity which far exceeded the maximum dosage of 30 ml on which the experts were agreed. The contention that it was possible that there was no causal relationship between the overdose and the convulsions was rejected by the Court. According to one of the expert witnesses she had not experienced a single case of allergy over a period of 12 years in which 2 400 babies had been given the contrast medium.

As far as the possibility of a congenital tendency towards epilepsy was concerned the Court pointed out that the state pathologist’s evidence had not been challenged, namely that if the epilepsy had been triggered by a normal dose of urografin, it would have been brief and controllable.

The conviction was confirmed.
9.6.5 Blood transfusion to wrong patient

In *S v Berman* (1996 TPD, unreported) a medical practitioner was convicted of culpable homicide as a result of a blood transfusion performed on the wrong patient. Dr N, a specialist gynaecologist, had on the same day performed operations on two of his patients, who bore the same surname and were in the same clinic, although in different parts. Unlike other hospitals which are divided into wards, this hospital was divided into sections, and the sections into wards.

The deceased, Mrs HV, received a blood transfusion before or during the operation. In the case of Mrs EV, Dr N directed that an urgent blood transfusion be performed after conclusion of the operation. A requisition and a blood specimen were sent to the J Blood Transfusion Service, of which the accused was an operator. In the application form a space was to be filled in under the word “ward”.

There the word “one” was inserted, but the word “ward” was not deleted and the word “section” not substituted. After the usual blood tests had been performed, two bottles of blood were handed to the accused by a technologist. Because the latter was aware of the subdivision and practice of the clinic in question, he wrote the patient’s name as well as “ward one” on the labels attached to the bottles.

When the accused arrived at the clinic he did not proceed to Section One but made enquiries at the reception desk, where he was directed to the wrong patient, Mrs HV, in Section Eight. There the accused enquired of the sister whether the patient was Mrs V, Dr N’s patient, to which the sister answered in the affirmative. The accused did not consult the bed letter of the deceased, on which was the name of HV (in large, legible letters), neither did he ask the deceased any questions to identify her.

He thereupon set up the transfusion apparatus and left. Shortly afterwards Dr N came to see the patient and he stopped the transfusion. The damage caused by the incompatibility of the infused blood was stopped, but upon a diagnosis of internal bleeding (a diagnosis which proved to be erroneous) a further transfusion of blood under pressure was given to the patient. This led to an overload of the heart and the patient died of heart failure.

The court (upon appeal) held that the accused...

... knew that the transfusion of blood into the wrong patient was in 99 per cent of cases the same as the injection of a potential killer poison into the patient’s veins. Based on his previous extensive experience the [accused] set out on what he knew or should have known to be a most hazardous mission if any mistake should be made. He knew or should have known that after certainty had been reached about the quality of the blood to be administered, the accurate identity of the recipient was paramount.

The court therefore held that the accused was properly convicted of culpable homicide in that he had failed to identify the deceased as being the patient who was to receive a blood transfusion.

9.6.6 Failure by doctor to care for patient post-operatively

In *S v Van Heerden* 2010 (1) SASV 529 (ECD) a specialist obstetrician and gynaecologist was charged with culpable homicide after the patient died from internal bleeding following a hysterectomy (removal of uterus). After the operation a nursing sister who cared for the patient...
in hospital noticed that her blood pressure was very low and her pulse very high. She testified that she was worried about the state of affairs, and that she phoned the accused, giving him the relevant information.

During the hearing the accused denied that the sister gave him the readings, but said that he gave her instructions over the phone on treating the patient for low blood pressure by putting her on a specific infusion. The accused did not immediately visit the patient in order to determine the cause of the low blood pressure and high pulse. Expert evidence indicated that these signs after an operation immediately create the suspicion of internal bleeding. The accused was on his way to a fertility clinic where he had an appointment with another patient, and therefore did not directly go and see the first patient. She died later that afternoon.

The trial court had to determine whether the accused was negligent in not immediately going to see the patient, and furthermore, whether her life could in fact have been saved if he did immediately step in to ensure that she receives the proper care. The court found that the moment the accused received the readings of her blood pressure and pulse he had a legal duty to go and see her. He failed to do so, and was thus negligent. Furthermore, there was an obligation on his side to take the necessary steps to stop the internal bleeding (indicated by the readings the sister gave him). He failed to do so and was thus also negligent in this regard.

In addition the court had to determine whether the life of the deceased could no longer have been saved had the accused been present at her bedside at the time when he could have been there had he reacted immediately. Expert evidence indicated that the deceased’s life could at that time still have been saved had the accused taken the necessary steps to stem the bleeding. A sufficient nexus was found between the negligence of the accused and the death of the deceased, and he was found guilty of culpable homicide.

However, on appeal the court set aside the conviction and sentence, mainly because it found the nursing sister’s evidence unreliable. This court thoroughly scrutinised the court record and found inconsistencies and improbabilities in the evidence. The court concluded that the sister probably did not give the patient’s blood pressure reading over the telephone to the accused, and that consequently he was not aware of the gravity of the patient’s condition. The court also accepted the evidence of the accused that, had he been informed of the gravity of the situation, he would immediately have visited her. The conviction and sentence were set aside.

9.7 Other offences

There are a number of other common-law offences which doctors may commit in the course of practising their profession, of which culpable homicide is by far the most important. We have already discussed murder. Other examples of such common-law offences are assault, criminal defamation, crimen iniuria, fraud, perjury, and contempt of court.

Statutory offences which doctors may commit during their professional career include those in terms of the Human Tissue Act 65 of 1983 (see 6.3.2.2), the Sterilisation Act 44 of 1998 (see 8.1.2 and 8.1.5), the Choice on Termination of Pregnancy Act 92 of 1996 (see 8.2.12 above, as well as 8.2.8), the regulations regarding artificial fertilisation (see 8.3.2.19 and 8.3.4), and the Children’s Act 38 of 2005 (see 8.4.12). Other statutory offences which we do not discuss here are those in terms of the Inquests Act 58 of 1959, the Births and Deaths Registrations Act 51 of 1992, the Mental Health Care

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Act 117 of 2002, the National Health Act 61 of 2003, and the Children’s Act 38 of 2005 (apart from those referred to above).

9.8 Relationship between criminal, delictual and disciplinary procedures

It stands to reason that a doctor found guilty of certain offences such as culpable homicide, murder, crimen iniuria (on account of invasion of privacy or violation of dignitas), assault, fraud or perjury in connection with a patient, may also incur private liability for the same conduct which leads to conviction of the relevant offence. The doctor may for example incur contractual or delictual liability in respect of the dependants of the breadwinner whose death he or she caused in an unlawful and negligent manner. Here the doctor’s conduct amounts to both culpable homicide and a delict, and it may also amount to breach of contract if there was indeed a contractual relationship between the doctor and the patient. (Because culpable homicide is the only common-law offence where proof of negligence is sufficient, it is the only offence of which a professionally negligent practitioner may be found guilty.)

Keep in mind what was said in 5.1 about liability on account of lack of informed consent.

The onus of proof in a civil case (such as a contractual or delictual claim) differs from that in a criminal trial: in a civil case the patient must prove his or her claim on a preponderance of probabilities; in a criminal trial the state has to prove its case beyond any reasonable doubt. Because it is much more difficult to prove a case beyond reasonable doubt than on a preponderance of probabilities, it is possible that a plaintiff may succeed with a civil claim even if the state has not been able to prove fulfilment of the requirements for culpable homicide.

Remember that there is an obligation on a court of law to inform the relevant professional board of prima facie proof of unprofessional conduct by a practitioner that comes to light during court proceedings (s 45(2) of the Health Professions Act 65 of 1974.) See 3.8.6 above. It is very possible that proof of an offence committed during a doctor’s practice will mostly also be prima facie proof of unprofessional conduct.

Also remember that if a practitioner before or after registration is found guilty of an offence by a
court of law, the professional board may take disciplinary action against such person if the board is of the opinion that such offence constitutes unprofessional conduct. The practitioner shall be liable on proof of the conviction to one or other of the penalties which may be imposed for unprofessional conduct. However, before imposition of any penalty such person shall be afforded an opportunity of tendering an explanation to the professional board in extenuation of the conduct in question (s 45(1) of the Health Professions Act 65 of 1974). See 3.8.6 above.

In 4.1.2 you got to know more about indemnity clauses which purport to exclude contractual or delictual liability. It is important to note that criminal liability cannot be excluded by way of an indemnity clause. An indemnity clause is a civil agreement between health care provider and patient. In a criminal case where a medical practitioner stands trial on charges of culpable homicide or murder, the state is the opposing party.

**ACTIVITIES**

1. A patient is chronically ill and constantly suffers severe pain. She suffers from insomnia and is very anxious. The doctor prescribes four types of medication: two strong painkillers, a sleeping tablet and a tranquilliser. Some days later the patient takes all the remaining tablets and capsules in one dosage. She loses consciousness, throws up, aspirates some of her vomit, and dies.

   Can the doctor on the basis of these events incur criminal liability? Discuss.

2. What important principles are illustrated by *S v Kramer*?

3. “Any want of knowledge, skill or competence required on the part of a doctor for him or her to be able to perform a certain intervention will be reckoned as negligence. If he or she should perform the intervention concerned without the necessary knowledge, skill or competence and the patient dies as a result thereof, the doctor would automatically incur liability.” Is this statement accurate in all respects? Comment critically.

4. Negligence is judged in the light of the surrounding circumstances. Name four considerations regarding the circumstances that are of special importance to medical law, explain each in one sentence, and give an example of each.

5. Sister Hubris terminates Dipuo’s pregnancy in the 27th week of the gestational period at a place which does not have appropriate infection control measures or emergency services. Sister Hubris did not complete the prescribed course for the termination of pregnancies. The abortion of the viable foetus fails. The child is born alive but dies a short while later in consequence of the substances administered and methods applied by Sister Hubris. Dipuo has lost a lot of blood and is still very weak. Sister Hubris sends her home. Dipuo dies, and the post mortem examination reveals that sepsis was the cause of death. Discuss Sister Hubris’ criminal liability.

6. Answer the following multiple-choice question: Which of the following statements is correct?

   (1) A doctor can protect himself or herself against any criminal, contractual, and delictual liability by having the patient sign an indemnity clause.
   
   (2) The same test is applied in both criminal law and the law of delict to determine whether a doctor acted negligently.
(3) In both a criminal and a civil case, the party who alleges negligence must prove on a preponderance of probabilities that the doctor was negligent.

(4) It is within the discretion of a court of law to decide whether to inform the relevant professional board of prima facie proof of unprofessional conduct by a practitioner that comes to light during court proceedings.

**FEEDBACK**

1. Define murder and culpable homicide – 9.3. Refer in your answer to the test for factual causation and the tests for legal causation – 9.4. Also apply the test for intention and the test for negligence – 9.3. The scenario does not furnish sufficient details to come to a definite conclusion. Suppose the patient was severely depressed and the doctor knew that she had made several suicide attempts in the past. The conclusion would differ dramatically from the one in a scenario where the patient had no such history and there were no signs of depression. Your answer must provide for different conclusions and the conditions or circumstances that would determine these conclusions. Therefore, the contents of 9.4.1 and 9.4.2 also have to be discussed.

2. The principle that

   - a person who accepts control over a dangerous situation/object is obliged to exercise proper control over it – the element of an act and the element of unlawfulness are relevant in this context (see 5.6.2.2)
   - a surgeon and an anaesthetist cannot be held liable for each other’s conduct – no vicarious liability for the conduct of an independent contractor (see 9.6.3 – more on this in 10.3.2)
   - the general rule directly above is subject to certain exceptions, for example where the surgeon was aware that the anaesthetist was incompetent or not fit to perform his or her duties (see 9.6.3 – more on this in 10.3.1, so-called culpa in eligendo)
   - a medical practitioner will not incur liability if he or she acts reasonably in an emergency situation (see 5.5.3)
   - the law cannot expect a person who has to act swiftly in a situation of sudden emergency to exercise the same level of judgment and skill as one who is not faced by such a situation – doctrine of sudden emergency (see 9.5.5)

3. It is inaccurate. The maxim imperitia culpae adnumeratur literally means that lack of knowledge, skill or competence will be reckoned as fault. However, it is not the lack of knowledge, skill or competence as such that is reckoned as fault. Rather, it is the fact that the doctor was aware or should reasonably have been aware that he or she did not have the necessary knowledge, skill or competence to give the particular advice or to perform the particular intervention that renders his or her conduct negligent. A doctor who ventures out on to an area of medicine while aware that he or she lacks the required knowledge, skill or competence is negligent in respect of a consequence that can be ascribed to such lack. The same can be said of one who ought to have known that he or she lacks the required knowledge, skill or competence. See 9.5.4.

Can you think of more principles?
4. **Consideration** | **Explanation** | **Example**
--- | --- | ---
1. Inherently dangerous substances, devices, or conditions | Greater care needed when working with something that is inherently dangerous | • R v Van Schoor – drug containing arsenic
• S v Bezuidenhout – contrast medium
• Childbirth

2. Doctrine of sudden emergency | The same level of skill and judgment cannot be expected of a person who faces a sudden emergency than can be expected of a person who does not face such a situation | S v Kramer – surgeon suddenly facing emergency of patient not receiving enough oxygen or anaesthesia

3. Patient suffers from some incapacity, defect, or allergy | Greater care needed when the patient suffers from some incapacity or defect that predisposes him or her to accidents | • Allergies
• Mentally confused, disoriented, comatose or intoxicated patient

4. Statutory provisions indicating negligence | Existence of a statutory provision may sometimes be indicative or afford proof of negligence | Regulation requiring competent person to ascertain that donor was tested for sexually transmissible diseases

5. This question involves criminal abortion, **murder** and **culpable homicide**. Sister Hubris committed an offence when she terminated a pregnancy after the 12th week of gestation. It also amounts to an offence to terminate a pregnancy at a place which does not have appropriate infection control measures. See **8.2.11**. Sister Hubris can be held liable for the death of Dipuo. An act, unlawfulness and causation have to be proven. It should be fairly easy in these circumstances. The question whether Sister Hubris would be convicted of murder or culpable homicide depends on whether the court finds that Sister Hubris caused Dipuo’s death intentionally or negligently. **Dolus eventualis** is sufficient for a conviction of murder. If Sister Hubris foresaw the possibility that Dipuo might die as a result of her act of abortion, and reconciled herself with this possibility, she can be convicted of murder.

If the state can prove that she negligently caused Dipuo’s death, she can be convicted of **culpable homicide**. The test for establishing negligence for the purposes of culpable homicide is set out in **9.5.2**. Ordinary negligence suffices – **9.5.3**. Sister Hubris ventured out on to an area for which she was not properly trained. The Choice on Termination of Pregnancy Act stipulates that only a doctor may terminate a pregnancy in the last trimester. **Imperitia culpae adnumeratur** applies – **9.5.4**. Relevant considerations when inquiring into negligence in these circumstances: abortion at such a late stage is inherently dangerous; the Choice on Termination of Pregnancy Act provides that a termination of pregnancy may only be effected at a...
place which has appropriate infection control measures. This provision affords proof that Sister Hubris was negligent with regard to the sepsis which led to Dipuo’s death – 9.5.5.4 and 8.2.7.

Sister Hubris can be convicted of culpable homicide for causing the little one’s death. If she foresaw the possibility that the baby may first be born alive and then die as a result of the attempted abortion, and reconciled herself with this possibility, she can be convicted of murder in respect of the baby’s death. The prenatal injuries led to the baby’s death after birth – see 9.4. (Had the baby been stillborn, the situation would be different – see S v Mshumpa, 9.3.1.)

6. The correct answer is (2). See 9.8.

(1) Criminal liability cannot be excluded in this manner.
(2) Correct. The criterion used when applying the test is that of the reasonable health care provider of the particular branch of the health care profession to which the accused or defendant belongs. The test applied is that of reasonable foreseeability and preventability of the result concerned. Keep in mind that the test is the same when studying study unit 10.
(3) In a criminal trial the state must prove the requirements for the crime beyond any reasonable doubt.
(4) The court of law is obliged to report it to the relevant professional board.

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**GLOSSARY**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>amenophylline</td>
<td>Drug for treating asthma. A bronchodilator – opens up the bronchi and bronchioles and relaxes the bronchial smooth muscle. Patient breathes more freely as the calibre of the bronchi is enlarged.</td>
</tr>
<tr>
<td>ampoule</td>
<td>Small glass or plastic vial which is sealed after filling; used mainly for holding sterile hypodermic (under the skin) fluid for injection. Has a narrow neck which is broken off so that the contents may be pulled up into the needle.</td>
</tr>
<tr>
<td>anaesthesia</td>
<td>Causing loss of feeling or sensation in part or whole of the body. When the entire body is involved and a state of total unconsciousness is induced, it is called general anaesthesia. When only part of the body is involved, it is called local anaesthesia. The latter may be combined with sedation, ie, causing a calmer state of mind with certain drugs.</td>
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<tr>
<td>anaesthetist</td>
<td>Doctor specialising in administering narcotic drugs. Note that the doctor who acted as anaesthetist in S v Kramer was not a specialist anaesthetist.</td>
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<tr>
<td>arsenic</td>
<td>Extremely poisonous metallic chemical element used <em>inter alia</em> in insect and weed killers.</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td><strong>assault</strong></td>
<td>Assault is committed when someone unlawfully and intentionally causes violence to the body of another, directly or indirectly, or leads another to believe that violence will be caused to him or her directly.</td>
</tr>
<tr>
<td><strong>blood transfusion</strong></td>
<td>Transfusion of blood or a component or product of the blood (red blood cells, platelets, plasma) from one person into the blood vessels of another in order to supplement blood loss through injury, surgery or illness. Donated blood is tested for blood group and certain communicable diseases, and is kept in a blood bank until needed. Before the transfusion it has to be ascertained that the blood of the donor and the patient is histologically compatible, as incompatible blood may have a negative reaction.</td>
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<tr>
<td><strong>Brandt-Andrews technique</strong></td>
<td>Technique to remove the <strong>placenta</strong> (afterbirth). One hand grips the umbilical cord while the other rests on the abdomen over the anterior aspect (front) of the placenta. While the hand on the abdomen presses back and somewhat upwards, the umbilical cord is gently pulled.</td>
</tr>
<tr>
<td><strong>breathing test</strong></td>
<td>A procedural provision in the Criminal Procedure Act 51 of 1977 providing that where an accused is charged with the killing of a newly-born child, such child shall be deemed to have been born alive if the child is proved to have breathed.</td>
</tr>
<tr>
<td><strong>bronchial asthma</strong></td>
<td>Illness of the lungs characterised by repeated attacks of dyspnoea (lack of breath; laboured breathing) with inflammation of the air passages. Wheezing of breath through spasmodic contraction of bronchi (larger air passages transporting air to and from lungs).</td>
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<tr>
<td><strong>cardiac massage</strong></td>
<td>Emergency medical procedure whereby rhythmic pressure is put on the heart to maintain blood circulation during cardiac arrest.</td>
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<tr>
<td><strong>contempt of court</strong></td>
<td>For purposes of this module – unlawful and intentional infringement of the dignity, repute or authority of a judicial officer in his/her judicial capacity, or of a judicial institution.</td>
</tr>
<tr>
<td><strong>contrast medium</strong></td>
<td>Substance such as iodine or barium, or air; used in radiological studies to enhance contrast and thus visibility of a picture. In X-rays a positive contrast medium absorbs X-rays better; a negative contrast medium is absorbs X-rays less effectively.</td>
</tr>
<tr>
<td><strong>crimen iniuria</strong></td>
<td>Unlawful, intentional and serious infringement of the dignity or privacy of another. Pronunciation: CREE-men in-YOU-ree-ah</td>
</tr>
<tr>
<td><strong>criminal defamation</strong></td>
<td>Unlawful, intentional publication of an accusation about someone else with the effect of grievously violating such person’s good name. Publication occurs when the defamatory words are brought to the attention of someone other than the defamed.</td>
</tr>
<tr>
<td><strong>culpable homicide</strong></td>
<td>Unlawful and negligent causing of the death of another person.</td>
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<tr>
<td>Term</td>
<td>Definition / Description</td>
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<tr>
<td>defibrillator</td>
<td>Apparatus used to counter ventricular fibrillation (fibrillation of a heart chamber) of the cardiac muscle and bring about a normal heart rate by administering short and controlled electric shocks. Ventricular fibrillation is quick, irregular, uncoordinated spasms of the individual muscle fibres of the ventricles of the cardiac muscle instead of the normal, synchronic contractions forming the pulse rate. It may lead to cardiac arrest.</td>
</tr>
<tr>
<td>dicta</td>
<td>Court findings.</td>
</tr>
<tr>
<td>Dicumarol</td>
<td>Anticoagulant – prevents blood clotting.</td>
</tr>
<tr>
<td>endotracheal tube</td>
<td>Catheter of the airways placed in trachea during endotracheal intubation up to the point where the trachea forks; ensures sufficient oxygen to lungs.</td>
</tr>
<tr>
<td>episiotomy</td>
<td>Incision in the area between the vagina and the anus (the perineum) during difficult confinement; widens vaginal opening in controlled manner to ease birth and prevent extensive tearing of tissue. Is performed when baby’s head has partially passed through birth canal.</td>
</tr>
<tr>
<td>fault</td>
<td>Intention or negligence.</td>
</tr>
<tr>
<td>femoral</td>
<td>Referring to thigh or femur; longest and thickest bone in the body; between pelvis and knee.</td>
</tr>
<tr>
<td>fraud</td>
<td>Unlawfully and intentionally making a misrepresentation resulting in real or potential damage to another.</td>
</tr>
<tr>
<td>gynaecologist</td>
<td>Doctor specialising in diagnosis and treatment of illnesses of the female reproductive organs.</td>
</tr>
<tr>
<td>halothane</td>
<td>Gas used in anaesthesia.</td>
</tr>
<tr>
<td>hypothetical</td>
<td>Supposed.</td>
</tr>
<tr>
<td>hysterectomy</td>
<td>Surgical removal of uterus or womb.</td>
</tr>
<tr>
<td>in utero</td>
<td>In the womb.</td>
</tr>
<tr>
<td>intensive care</td>
<td>Ongoing, extensive, controlled monitoring of acutely or critically ill patients.</td>
</tr>
<tr>
<td>intensive care unit</td>
<td>Special section in hospital with requisite equipment, medical and nursing staff and monitors to render intensive care.</td>
</tr>
<tr>
<td>laryngoscope</td>
<td>Endoscope or apparatus (hollow tube with electric light and mirrors) inserted through the mouth into the larynx to examine the larynx.</td>
</tr>
<tr>
<td>larynx</td>
<td>Voice box; part of air passage between pharynx and trachea. Tube consisting of cartilage and muscle, lined with mucus membrane. Vocal cords lie in larynx.</td>
</tr>
<tr>
<td>murder</td>
<td>Unlawful and intentional causing of the death of another person.</td>
</tr>
<tr>
<td>muscle relaxant</td>
<td>Substance that relaxes muscles. With anaesthesia during surgery certain muscle relaxants are given together with pain medication to relax muscles.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>narcotic drug</td>
<td>Drug causing temporary loss of sensation or feeling; administered to shut out pain so that surgery may be performed.</td>
</tr>
<tr>
<td>Neo-Halarsine</td>
<td>Drug containing arsenic; previously used to treat syphilis.</td>
</tr>
<tr>
<td>novus actus</td>
<td>Literally: “new intervening act/event”. Unexpected, abnormal or extraordinary event, deviating, according to general human experience, from the normal run of events. Pronunciation: NO-vous UC-toos in-ter-veh-knee-ENCE</td>
</tr>
<tr>
<td>interveniens</td>
<td></td>
</tr>
<tr>
<td>paraldehyde</td>
<td>Drug with strong sedating (calming) and hypnotic (sleep-inducing) action; seldom used on account of its low therapeutic index.</td>
</tr>
<tr>
<td>pentothal</td>
<td>A narcotic drug.</td>
</tr>
<tr>
<td>perjury</td>
<td>Unlawful and intentional making of a false statement (or after attestation or warning to speak the truth) under oath, administered by a person with the power to administer an oath (or to receive the attested declaration or direct the warning), which statement is made during the legal process, and is relevant to a point of dispute.</td>
</tr>
<tr>
<td>pharynx</td>
<td>Part of the throat between mouth and larynx (voice box).</td>
</tr>
<tr>
<td>physiological</td>
<td>Pertaining to the science studying the functioning of living organisms and their parts, and the relevant physical and chemical processes and factors.</td>
</tr>
<tr>
<td>placenta</td>
<td>Membrane-like organ in uterus, rich in blood vessels; attaches embryo to inside of uterus, enabling selective exchange of soluble substances between mother and foetus. Allows infusion of oxygen and nutrients into foetal blood vessels. Carbon dioxide and waste products are eliminated from the foetal blood via the placenta. After the birth the placenta normally disengages from the uterus and is pushed out. Also known as the afterbirth.</td>
</tr>
<tr>
<td>principle of legality</td>
<td>The principle of legality prevents an accused to be found guilty of an offence if his or her actions were not acknowledged as an offence at the time when these were committed, in language that is not vague, but not having to word the offence in such a manner that the conduct of the accused may be included therein.</td>
</tr>
<tr>
<td>radiographer</td>
<td>Technician trained to capture radiological images on photographic plates or fluorescent screens, and to perform other radio-diagnostic procedures. Duties include positioning of patient for radiological examination; establishing correct tension, current-strength, and duration of the exposure for every image, and adjusting radiographic equipment; capturing images as requested; developing X-ray film; helping radiologist with special procedures and preparation of contrast medium.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
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<td>---------------</td>
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</tr>
<tr>
<td>radiologist</td>
<td>Doctor specialising in the medical field concerned with diagnostic reproduction of anatomic structures by means of electro-magnetic radiation or sound-waves (diagnostic radiology); treats illnesses with radioactive substances (therapeutic radiology; radiotherapy). Radiological techniques include X-rays, computer tomography (CAT scan), positron-emission tomography (PET), magnetic resonance imaging (MRI) and ultra-sound imaging. See “radiographer”.</td>
</tr>
<tr>
<td>scolene</td>
<td>Muscle relaxant.</td>
</tr>
<tr>
<td>shock</td>
<td>Shock occurs when the circulatory system is unable to ensure sufficient perfusion (rinsing) of vital organs due to difference in volume of the available blood in circulation and the volume of the vascular bed (sum total of blood vessels). The arterial pressure is thus too low to ensure sufficient blood supply. The patient’s skin is cold, sweaty and pale; pulse is weak, breathing irregular; he has a dry mouth, enlarged pupils and decreased urinary flow.</td>
</tr>
<tr>
<td>sodium chloride</td>
<td>Table salt. Chemical formula: NaCl.</td>
</tr>
<tr>
<td>syphilis</td>
<td>Venereal disease caused by the micro-organism Treponema pallidum. Transmitted by direct contact, usually sexual relations, or in utero from mother to child. The illness progresses in three stadia, characterised by the following: primary phase – venereal ulcers; secondary phase – skin abscesses (chancres), and the potentially deadly third phase: systemic infection and general inhibition of (neurological) motor functions.</td>
</tr>
<tr>
<td>t.d.s.p.c.</td>
<td>Abbreviation for the Latin ter die sumendum post cibum, used by pharmacist; means “three times a day after meals”.</td>
</tr>
<tr>
<td>thrombosis</td>
<td>Forming (or presence) of a blood clot or thrombus totally or partially blocking a blood vessel. The thrombosis may lead to an infarct or localised tissue necrosis due to insufficient blood supply.</td>
</tr>
<tr>
<td>trachea</td>
<td>Cartilage-like pipe stretching down from the larynx to where it divides into the left and right bronchus.</td>
</tr>
<tr>
<td>urografin</td>
<td>A multi-purpose radiological contrast medium.</td>
</tr>
<tr>
<td>urological</td>
<td>Pertaining to urology. Urology is the branch of medical science concerned with diagnosis and treatment of diseases of the urinary tract and uro-genital system.</td>
</tr>
<tr>
<td>ventricles (of the heart)</td>
<td>The two bottom heart chambers with thick muscular walls. The left ventricle receives blood from the pulmonary veins via the left atrium and pumps it to the aorta (main artery). The right ventricle receives blood from the venae cavae via the right atrium and pumps it to the pulmonary artery.</td>
</tr>
<tr>
<td>Vitamin K</td>
<td>A fat-soluble vitamin which promotes blood clotting and prevents excessive bleeding.</td>
</tr>
<tr>
<td>white leg</td>
<td>Painful inflammation and thrombosis of femoral (thigh) vein after childbirth. Characterised by swelling of the leg.</td>
</tr>
</tbody>
</table>
STUDY UNIT 10

Delictual liability

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Activities
Feedback
Glossary

LEARNING OUTCOMES

When you have completed this study unit, you should be able to

- distinguish between liability on the part of a doctor (or other health-care provider) for intentional wrongdoing and negligent misconduct
- explain the need for patient confidentiality, and assess potential liability for breaches of the duty of health personnel to maintain confidentiality
- discuss the legal standard set for assessing medical negligence, and the problems of proof experienced by aggrieved patients who want to recover damages for alleged medical negligence
- explain the concept of vicarious liability and its importance in enabling aggrieved patients to sue employers for the negligence of their staff
10.1 Introduction

As opposed to a crime, which is an wrongful act that may result in conviction and sentencing of the perpetrator in a criminal court, a delict is a civil wrong which is not punishable as such, but may result in a verdict by a (civil) court that the wrongdoer must pay damages to the injured party.

A delict may be described as the act of a person that in a wrongful and culpable way causes harm to another (see Neethling et al 3). All five the requirements or elements of a delict must be present before the conduct complained of may be classified as a delict. These requirements are

(1) an act
(2) wrongfulness
(3) fault (or culpability)
(4) harm
(5) causation

10.1.1 Relationship between the law of delict and medical law

A doctor, other health care worker or health care provider such as a hospital can incur delictual liability for wrongful conduct which caused harm to a patient if such conduct involved fault in the form of either intention or negligence. Think for example of an operation going wrong because a doctor or nursing sister was not properly trained. Who is liable for harm or loss to the patient as result of such incompetence? Another example is the doctor who discusses a patient’s situation with another doctor without the patient’s consent. Has a delict been committed?

Where an agreement between the doctor and patient exists the patient’s remedy is not limited to a contractual claim. The patient may also institute a delictual claim.

10.1.2 Delictual actions and medical law

In the law of delict you learnt that there are three delictual actions, namely

- the *actio legis Aquiliae* by means of which compensation may be claimed for patrimonial loss caused in a wrongful and culpable (negligent or intentional) way
- the action for pain and suffering by means of which compensation may be claimed for non-patrimonial loss such as pain, suffering, bodily disfigurement, loss of amenities of health, emotional shock, loss of amenities of life, and loss of life expectancy caused in a wrongful and culpable (negligent or intentional) way
- the *actio iniuriarum* by means of which satisfaction (*genoegdoening*) may be claimed for non-patrimonial loss resulting from a wrongful and intentional infringement of a personality interest such as physical integrity, dignity or privacy (there are a few exceptions to the rule that intention is required)

Consider for a moment the type of conduct that might give rise to a claim in the medical law context. A doctor may for instance negligently make an incorrect diagnosis of a patient’s ailment. That might lead to inappropriate treatment of the patient. It may also lead to a loss of life expectancy and the amenities of health if, for instance, the doctor negligently failed to diagnose cancer in its early stage. Negligence may enter the picture even earlier, as would be the case where the doctor negligently failed to properly examine the patient. A medical practitioner may use inappropriate or defective
instruments when performing an operation; leave behind a swab or instrument in the patient’s body after an operation; operate upon or amputate the wrong organ or limb; follow the wrong procedure in setting a fractured arm or leg, for instance, resulting in the shortening or contracture of the limb; tug too hard when taking a biopsy, causing a blood vessel to rupture; administer an overdose of medication, contrast medium or radiotherapy; discharge a patient prematurely from hospital or fail to provide proper post-operative care; completely fail to perform an agreed intervention (such as a sterilisation); infect a patient with a communicable disease such as AIDS (through a blood transfusion, for instance); fail to refer a patient to a specialist or to call upon a specialist for assistance where such referral or assistance was necessary; make use of an incompetent assistant during an operation; perform an unnecessary operation or administer unnecessary treatment; conduct a reckless experiment on a patient; fail to record an allergy from which the patient suffers, and then administer a substance to which the patient is allergic. A professional nurse may, for instance, perform an illegal abortion which causes the patient harm; or fail to apply the necessary care with the result that a patient becomes dehydrated as a result of a malfunctioning drip, or falls out of a bed after surgery, or suffers oxygen deprivation because the tracheotomy tube becomes dislodged. An anaesthetist may administer too little anaesthesia, causing the patient to experience terrible pain during an operation; administer the wrong gasses because of incorrect coupling of the pipes supplying the gasses; or fail to effect a proper intubation of the patient, resulting in brain damage.

Suppose a doctor performs an operation in a negligent manner. The patient’s health is impaired, her life expectancy is shortened, she suffers a loss of income owing to her inability to work, and she incurs additional medical expenses because of the doctor’s wrongful and negligent conduct. Which actions does this scenario involve?

The legal practitioner must ensure that the summons contains all the relevant elements required for liability in order to ensure that the defendant does not bring an exception against it on the ground that it does not reveal a cause of action. The plaintiff will succeed with her action if she manages to prove on a preponderance of probabilities that the defendant’s wrongful and negligent conduct caused the alleged harm. The actio legis Aquiliae and the action for pain and suffering concur in this instance, since the wrongful and negligent infringement of the patient’s physical integrity also led to patrimonial loss (the additional medical expenses and the loss of income).

Take the above scenario. Suppose the doctor failed to obtain the patient’s informed consent before the operation. No other ground of justification was present. Since any infringement of a person’s physical integrity is prima facie wrongful, and there is no ground of justification present, the operation constitutes an assault. The operation further led to the harm set out above. Which actions are involved here?

In addition to all the elements set out above, the summons must contain the allegation that the defendant wrongfully and intentionally infringed upon the patient’s right to physical integrity by subjecting her to an operation without her valid consent (ie, an allegation of assault). In this instance, the actio legis Aquiliae, the action for pain and suffering, and the actio iniuriarum concur.
Suppose a medical practitioner reveals certain confidential and unsavoury medical information about his patient to the press. The press blurts out the information, and the patient, a professional, loses a considerable number of clients as a result of the medical practitioner’s act. Which actions does this scenario involve?

In this instance, there is a concurrence of the *actio iniuriarum* and the *actio legis Aquiliae*. Negligence (at the least) must be alleged and proved in respect of the patrimonial loss, and intention must be alleged and proved in respect of the infringement of privacy.

It is clear that patrimonial as well as non-patrimonial loss may be recovered in delict. We have already pointed out that non-patrimonial loss may not be recovered in contract (see 4.1.1.7 above). This is an important difference between delictual and contractual liability. You will get a better idea of what this difference means in practice when studying study unit 11.

When claims for medical negligence are argued in court it often happens that the parties agree to separate the merits of the case and the *quantum* (the amount of the damages) thereof, in order first to ascertain whether the defendant is liable before deciding on the amount of the damages. Rule 33(4) of the Uniform Rules of Court makes provision for such an arrangement. In exceptional cases the parties may agree beforehand on the amount of damages to be paid in the event that negligence is proven.

10.2 Elements of a delict within the framework of medical law

We do not intend to set out all the elements of a delict in detail. We will only focus your attention on those aspects of each element that deserve special consideration in the medical law context.

10.2.1 Act

It is important to remember that, especially in cases of medical negligence, an omission or failure to act may also constitute liability on the grounds of a delict. This is made apparent by the examples cited in 10.1.2 above of the type of conduct that may found a claim.

10.2.2 Wrongfulness

To determine whether an act is wrongful the *boni mores* test is applied. See *Clarke v Hurst NO* (6.2.3.2) where the court found that it would not be *contra bonos mores* to switch off the life-sustaining machines in those circumstances. The act was thus not wrongful.

Practically speaking, conduct is *contra bonos mores* either because it infringes a legally recognised interest (or subjective right) or because it violates a legal duty. If a person infringes upon another’s legally recognised interest, his or her conduct is wrongful unless justified by some ground of justification, such as consent, *negotiorum gestio*, necessity or statutory authority (see study unit 5).

Where there is a legal duty on a person to perform a certain act in certain circumstances, and the person fails to perform such act, his or her conduct would also be deemed wrongful. The legal
convictions of society (boni mores) also determine whether such legal duty rests on a specific person. See 5.6. In the case of an omission or the causing of pure economic loss, wrongfulness is usually determined by asking whether a person had a legal duty to avoid the loss, rather than by asking whether a subjective right (or legally recognised interest) was infringed.

10.2.3 Fault

Fault may take one of two forms, namely intention or negligence.

10.2.3.1 Intention

As we have seen, fault in the form of intention is required for the actio iniuriarum. Whenever an action is brought against a medical practitioner for the alleged wrongful infringement of a patient’s personality interests, the plaintiff must prove intention on the part of the medical practitioner. In medical law there are two types of cases involving the infringement of a patient’s interests of personality that occur with some frequency. The first is infringement of a patient’s privacy, which is discussed in (b) below.

The second occurs where the doctor subjects the patient to an intervention without the patient’s consent, and the patient institutes an action for the infringement of his or her physical integrity (ie, assault) or dignitas (ie, iniuria). This type of case is discussed in (a) directly below. Note that this is not an action for the recovery of damages that ensue from the assault or iniuria, but one by means of which satisfaction is sought for the infringement of a personality interest (physical integrity or dignitas). If further loss ensued as a result of the assault, it may be claimed by means of the actio legis Aquiliae or the action for pain and suffering – depending on the type of loss or harm suffered – for which proof of negligence would suffice. If no patrimonial loss resulted from a doctor’s wrongful infringement of a patient’s interests of personality, nor any non-patrimonial loss recoverable with the action for pain and suffering, the patient can only claim satisfaction (compensation) with the actio iniuriarum and needs to prove intention.

(a) Medical treatment without consent

Medical treatment without the informed consent of the patient prima facie constitutes an assault and will be wrongful unless justified by some other ground of justification, such as negotiorum gestio or statutory authority (see our discussion in study unit 5). In Stoffberg v Elliott 1923 CPD 148 it is explained as follows:

In the eyes of the law, every person has certain absolute rights which the law protects ... and one of those rights is the right of absolute security of the person. Nobody can interfere in any way with the person of another, except in certain circumstances which I will further explain to you. Any bodily interference with or restraint of a man’s person which is not justified in law, or excused in law, or consented to, is a wrong, and for that wrong the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to that interference.

In Burger v Administrateur, Kaap 1990 1 SA 483 (K) 489 the court unambiguously stated: “It is very clear that ... where a doctor ... operates on a patient without consent, it is an assault”. [Our translation.]
The doctrine of informed consent is discussed in detail in study unit 5. We saw that consent to a medical intervention would be valid in law only if the requirements of doctrine of informed consent were met. Put differently: absence of informed consent is tantamount to absence of consent (see 5.1). Therefore, it follows that the plaintiff is indeed required to prove intention if it is satisfaction for the infringement of his physical integrity that he is after. Intention includes awareness of wrongfulness, which means that the patient must also prove that the doctor foresaw the possibility of the patient's consent being invalid, and reconciled himself to that possibility.

In *Broude v McIntosh* 1998 (3) SA 60 (SCA) (the facts were discussed briefly in 5.3.4 above) a doctor was sued by a patient for assault on the basis of alleged lack of informed consent. The patient alleged that the doctor failed to inform him of the risk of leaking of cerebrospinal fluid during the operation. The Supreme Court of Appeal in a full-bench judgment (per Marais JA) held as follows (at 68 F–G):

> The omission to inform appellant of the risk of leakage of cerebrospinal fluid was of no significance. The leakage was not proved to be causally related to the onset of the facial palsy and appellant did not claim that if the risk of leakage had been mentioned to him, he would have refused to consent to the operation.

The Supreme Court of Appeal confirmed the finding of the court a quo and dismissed the appeal. In this full-bench judgment the court (per Marais JA) expressed the following reservations:

> Pleading a cause of action such as this as an assault to which the patient did not give informed consent is of course a familiar and time-honoured method of doing so. However, I venture to suggest with respect that its conceptual soundness is open to serious question and merits reconsideration by this Court when an appropriate case arises. To the average person, and I suspect to many a lawyer, it is a strange notion that the surgical intervention of a medical practitioner whose sole object is to alleviate the pain or discomfort of the patient, and who has explained to the patient what is intended to be done and obtained the patient's consent to it being done, should be pejoratively described and juristically characterised as an assault simply because the practitioner omitted to mention the existence of a risk considered to be material enough to have warranted disclosure and which, if disclosed, might have resulted in the patient withholding consent. It seems to me to be inherent in the notion that, even if the risk does not eventuate and the surgical intervention is successful, the practitioner's conduct would nonetheless have constituted an assault. That strikes me as a bizarre result which suggests that there is something about the approach which is unsound. There is no principle of law of
which I am aware by which the characterisation as lawful or unlawful of an intentional act objectively involving the doing of bodily harm to another can be postponed until its consequences are known. Either it was an assault at the time of its commission or it was not. Events occurring ex post facto can logically have no bearing on the question. It is no answer to say that if the undisclosed risk does not eventuate, no damage will have been caused. That has nothing to do with the characterisation of the medical practitioner’s act in intervening surgically as lawful or unlawful. I mention this merely by way of example to explain why I consider that the validity of causes of action framed in this manner in circumstances similar to those which are said to exist in this case requires re-examination. (I emphasise the latter qualification; I leave aside cases in which mala fides is involved such as cases of deliberate fraud and deliberate misrepresentation of what is entailed in order to obtain consent which would otherwise not be forthcoming.) However, re-examination would be inappropriate in the present case. The matter was not argued and even if it be assumed in favour of appellant that the cause of action based upon an allegation of assault is conceptually sound in law, I agree with the trial Judge’s conclusion that the evidence does not bear it out.

The above was however only mentioned obiter dictum in the finding, and is therefore not binding.

In our opinion, the obiter dictum by Marais JA is untenable. When dealing with a lack of informed consent, it is imperative to distinguish between the various forms of harm that may result, and to keep in mind the requirements for liability in terms of the actions involved. As pointed out above, it is an undeniable fact that a wrongful and intentional infringement of a patient’s physical integrity constitutes assault. From the above excerpt it would appear as if Marais JA lost sight of the fact that the mere infringement of the patient’s physical integrity already constitutes an infringement of a personality right even in the absence of any consequential loss. According to the honourable judge of appeal, the damage would only ensue if the undisclosed risk would eventuate. We are of the opinion that the operation itself is wrongful because it is not justified by consent or any other ground of justification. Therefore, the characterisation of the doctor’s act as wrongful need not be postponed until some consequential loss ensues, because non-patrimonial harm is present the moment the doctor subjects the patient to the operation without his legally valid consent. Unlawfulness does not depend on the setting in of further loss. Van Oosten carefully analysed the legal consequences of a lack of informed consent (see Van Oosten FFW The doctrine of informed consent in medical law (Frankfurt am Main, P Lang 1991) 452–455). He made a number of submissions in this regard with which we agree. We therefore submit the following:

- A medical intervention without informed consent constitutes assault. The plaintiff will succeed with an action seeking satisfaction (non-patrimonial damages) for the infringement of her or his physical integrity only if intention is proved. Intention entails both direction of the will and awareness of wrongfulness.
- If the intervention was performed without informed consent, but with due care and skill and does not result in any harm to the patient’s health, she or he can still claim satisfaction for the assault. If the patient’s dignitas was also impaired by the doctor’s act, satisfaction for such iniuria may be claimed in addition. Harm is therefore restricted to the infringement of personality rights, and only non-patrimonial damages caused in an intentional way can be claimed.
- If an undisclosed risk does materialise and harms the patient’s health, the plaintiff can also claim for any loss caused through negligence. However, causation must be proved. This means that the plaintiff can succeed with such an action only if she or he would not have consented to the intervention had she or he been properly informed of the risk. If the patient would nevertheless have consented to the intervention, a causal connection between the non-disclosure and the
harm ensuing as a result of the intervention will be lacking, and the patient’s claim will be limited to non-patrimonial loss recoverable by means of the actio iniuriarum (satisfaction for the infringement of personality rights).

(b) Invasion of privacy

Intention is also required for liability owing to an invasion of privacy. Privacy can be infringed only through acquaintance with personal facts by outsiders contrary to the determination and will of the person whose right is infringed (see Neethling J, Potgieter JM en Visser PJ Neethling’s Law of Personality (2005) 221 ff). The doctor’s duty to maintain confidentiality plays an important role in respect of protecting a patient’s right to privacy. Note, however, that a health care provider can infringe a patient’s right to privacy without violating the duty of confidentiality. In the context of medical law there are two ways in which personal facts may be found out, namely by

1. acquiring knowledge of the patient’s private personal facts, or intruding on the patient’s private sphere
2. revealing or disclosing the patient’s private personal facts to another

If a doctor would for example secretly have genetic tests done on a blood sample taken with the patient’s consent, it would amount to invasion of privacy through acquiring knowledge of the patient’s private personal facts, or intrusion ((1) above) without the doctor failing in his duty of confidentiality. However, if the doctor should reveal the results of the tests to another, it would amount to invasion of privacy through revelation or disclosure ((2) above). In this case the doctor’s conduct would amount to violation of his duty of confidentiality.

From the doctor-patient relationship follows the duty of the doctor to maintain confidentiality concerning the patient’s ailment and the treatment given to him. This duty is of a legal as well as an ethical nature. In terms of the ethical rules of conduct made by the Health Professions Council of South Africa (and published in GN R717, GG 29079 of 4 Aug 2006, as amended) a medical practitioner may only divulge information regarding a patient which he or she has to divulge in terms of a statutory provision, at the instruction of a court of law, or where justified by public interest (Rule 13(1)). Rule 13(2) prohibits the divulging of information which ought not to be divulged in terms of Rule 13(1), except with the express consent of the patient, or, in the case of a minor under the age of 12, with the written consent of his or her parent or guardian, or, in the case of a deceased patient, with the written consent of his or her next-of-kin or the executor of such deceased patient’s estate.

In respect of the statutory provisions for protection of the patient’s privacy, see the provisions of the Constitution, 1996, as well as of the National Health Act 61 of 2003 discussed in 1.5 above. Also see 3.15 where access to health records was discussed.

An actionable invasion of a patient’s privacy will result in the doctor incurring liability under the actio iniuriarum. The principles relating to violation of privacy will not be discussed here in any detail. Suffice it to say that a doctor can escape liability only if he can advance a recognised ground of justification, such as the patient’s consent, necessity, private defence, privileged occasion or public interest.
In 5.5.3.1 we met Dr Rose Thornton, sister Merryweather and Maleficient, the difficult patient who did not want to allow the taking of a blood sample from her for HIV testing. And this after Dr Thornton pricked her own finger with a needle, and wanted to take a blood sample in order to ascertain whether she had to take antiretroviral drugs to prevent HIV transmission. Say the situation differed in the following respect: Dr Thornton had already taken a blood sample from Maleficient, with the latter’s permission, before she pricked her finger, in order to have other tests done. After pricking her finger the doctor asked permission to have an HIV test done. Maleficient refused. Do you think Dr Thornton could rely on a ground of justification to have such test done without Maleficient’s permission?

An important judgment of the Appeal Court on violation of privacy through revelation or disclosure was *Jansen van Vuuren NNO v Kruger* 1993 (4) SA 842 (A). This case deals with a doctor’s duty towards his patient who has AIDS. The court stressed the legal nature of a doctor’s duty to respect the confidentiality of his patient. The duty is nevertheless not absolute but relative: a doctor could be justified in disclosing his knowledge of the patient’s HIV status where the doctor’s obligations to society were of greater weight than his obligations to the individual. But on the facts of the case before it, the court ruled that the doctor’s disclosure was not justifiable.

The appeal was against the judgment of the Transvaal Provincial Division of the Supreme Court, denying a claim for damages by Mr M, a patient with AIDS, against Dr K. M alleged that Dr K had, in breach of a duty of confidentiality owed to him as his patient, disclosed to others the test results of his HIV status.

The relevant facts of the case were as follows: M had lived in a homosexual relationship with one V in the Transvaal town of B. They were fairly well-known residents of the town and the nature of their relationship was either generally known or surmised. During 1990 they began a business venture and moved to another Transvaal town, retaining some links with B. M applied for life insurance and had to submit to the usual medical examination, including a test for HIV. M nominated Dr K to prepare the medical report. A blood sample was taken and the laboratory informed the doctor that the test was positive. Dr K arranged for an appointment with M in order to consult with him on the outcome of the test. M was extremely upset and distressed. He was also concerned about a possible leak, and raised the issue with Dr K, who promised to respect his wish to keep it confidential.

The following day, in the course of a game of golf with Dr X, also a general practitioner, and a dentist, Dr K disclosed Mr M’s condition to them. M and these three doctors moved in the same social circle in the town of B. M was engaged in a business venture with Dr X’s wife. M had in the past been a patient of the dentist. Dr K’s ex-wife and her parents were on friendly terms with V. The news spread and M became aware of this fact. M was annoyed and took steps to establish the source of the breach of confidence. In due course he sued Dr K for R250 000 damages. He alleged a breach of a term of the agreement which established the doctor-patient relationship, and also contended that the disclosure of the test result amounted to an invasion of his rights of personality and his right to privacy. Dr K denied making the alleged disclosure; alternatively, he pleaded that the disclosure had been justified in law, *inter alia* on the grounds that it was made on a privileged occasion and that it was the truth and in the public interest.
During the trial Dr K testified that the dentist had been his patient and Mr M’s dentist. He (Dr K) was therefore concerned that M might have infected the dentist. He felt obliged to inform the dentist of M’s condition to enable him to evaluate his own exposure to the virus. It was not, however, his intention to discuss the matter with him at the stage when they played golf. Nevertheless, Dr K testified, in the course of the game a general discussion about HIV-infection had taken place, and in order to stress the immediacy of the problem, he told his two golf partners that he had a patient, known to all of them, who had tested positively. Dr X then remarked that he wondered whether it was not M, since he had consulted him about an oral fungal infection. K confirmed the correctness of Dr X’s surmise and asked him to treat the information confidentially.

K’s evidence was accepted by the trial court. Although the Appeal Court had some reservations about this finding, the latter court assumed its correctness for the purposes of its decision. The trial court had found that the disclosure was legally justified. As far as K knew at the time of the disclosure, Mr M was still the dentist’s patient, and was likely to be treated by him in future. As concerned his colleague, X: he was one of a group of 16 doctors in B who were on call from time to time for all off-duty practitioners in town. In the view of the trial judge it was required that he should be informed for his own sake, as well as for the better treatment of M, should the occasion arise.

The Appeal Court – consisting of five judges – took a different view, though. In its judgment it drew attention to the fact that M had moved to another town. The likelihood of him calling on either the dentist or Dr X was remote. “If the argument is taken to its logical conclusion,” the court stated, “health-care workers, at least those in Transvaal, would have to be informed.”

In determining whether Dr K had a social or moral duty to make the disclosure, and the other two doctors had a reciprocal social or moral duty to receive it, the standard of the reasonable man applies. With that in mind, the court ruled, there had been no such duty. True, the court said, AIDS is a dangerous condition. That on its own does not detract from the right of privacy of the afflicted person, especially if that right is founded in the doctor-patient relationship. A patient has the right to expect due compliance by the practitioner with his professional ethical standards ...

In this case, the court emphasised, the expectation had been even more pronounced because of the express undertaking by Dr K. The court concluded that communication to Dr K’s colleagues had been “unreasonable and therefore unjustified and wrongful”.

In the event, damages in the amount of R5 000 were awarded by the Court of Appeal, and Dr K was ordered to pay costs. (It is to be noted that Mr M had died prior to the conclusion of the trial, and that it was the executors of his estate who had lodged the appeal. The damages recovered would therefore have been credited to the deceased’s estate.)

This judgment is perhaps the most emphatic judicial ruling in South Africa stressing that medical confidentiality is not merely a matter of professional ethics but also a legal duty, the breach whereof may result in legal liability. As the court pointed out, per Harms AJA, the law protects a person’s dignitas, and dignitas embraces privacy. “In the present case we are concerned with the alleged invasion of [the right to privacy] by means of a public disclosure of private facts.” The court drew attention to the ancient origin of the doctor’s duty to maintain confidentiality:

As far as the public disclosure of private facts is concerned, the Hippocratic Oath, formulated by the father of medical science more than 2 370 years ago, is still in use. It requires of the
medical practitioner “to keep silence” about information acquired in his professional capacity relating to a patient, “counting such things to be as sacred secrets”.

In this respect the court also referred to the fact that inter alia Brahmin priests and priest-healers in Egypt in ancient times had already been warned to adhere to the duty of confidentiality. The name used for medicine, ars muta (dumb art) was used in Roman poetry by Virgil. The Pythagorean school in Greece, to which medical practitioners in particular belonged, considered silence as one of the most important virtues.

The Appeal Court also made specific reference to the ethical rule of the SA Medical and Dental Council regarding professional secrecy, and its 1989 guidelines on AIDS. The judgment again confirms the importance that the courts attach to ethical viewpoints of a professional body such as the Council (now replaced by the Health Professions Council of South Africa).

Taking a blood sample in order to test for HIV without the relevant person’s consent has also been considered by our courts. In C v Minister of Correctional Services 1996 (4) SA 292 (T) C claimed damages for wrongful invasion of his privacy. A blood sample was taken from C in order to test for HIV while he was in prison. Correctional Services had guidelines on how to obtain informed consent from prisoners for the purpose of HIV tests. The guidelines provided for adequate counselling before taking the HIV test. During counselling the prisoner has to be given the opportunity to give informed consent for the test to be taken. The employee taking the blood sample did not know about the guidelines, and did not obtain consent in terms thereof. C merely had the opportunity to refuse the taking of the blood sample as well as the HIV test. The information given to C was done in a group, and not individually by a trained counsellor. The court found (at 301) that informed consent is only valid if the prisoner understands what the purpose of the test is, what a positive HIV result entails, and that there is a possibility that AIDS might develop afterwards.

The defendant alleged that the requirements for animus iniuriandi (a requirement to succeed with the actio iniuriarum) were not proven because the employee did not know that he was acting wrongfully. (Awareness of wrongfulness is normally an element of intention.) However, the court found that this case belonged to a limited class of delict where awareness of wrongfulness is not required. Thus the court found that all the requirements for animus iniuriandi had been proven, and that C’s right to privacy had indeed been infringed.

10.2.3.2 Negligence

The delictual liability of the doctor for negligence is a subject which has enjoyed considerable attention in the courts. We do not intend discussing this subject in detail. We do, however, draw your attention to important principles which you should know and study for examination purposes. It is important to note that the discussion of negligence in the context of criminal liability (study unit 9) is also applicable in the present context. The criterion applied in determining negligence for the purposes of criminal liability is the same as that applied when enquiring into negligence for the purposes of delictual liability (see 9.5.1). The test is also the same, the only difference being that when determining negligence for the purposes of culpable homicide, the question is whether the reasonable health care professional of the particular branch of the health care profession concerned would have foreseen and prevented the patient’s death, while the question when determining negligence for the purposes of delictual liability is whether the said reasonable health care professional would have foreseen and prevented the harm suffered by the patient.
(a) The concept of negligence

Negligence refers to the blameworthy attitude or conduct of someone who has acted wrongfully. The blameworthiness is to be found therein that on account of carelessness, thoughtlessness or imprudence the person failed to adhere to the standard of care legally required of him or her. See Neethling et al 116.

(b) The standard of care

The standard of care required of a medical practitioner who undertakes the treatment of a patient is not the highest possible degree of professional skill, but reasonable skill and care. In the case of an expert health care practitioner, such as a doctor, negligence is established by finding an answer to the question how a reasonable health care practitioner belonging to the particular branch of the health care profession concerned would have acted in the same circumstances (compare 9.5.1).

The principle that only a reasonable degree of skill and care could be expected of a doctor (and not the highest degree) was reaffirmed in Van der Walt v De Beer 2005 (5) SA 151 (C). This case concerned the question whether a specialist (the defendant, in this case an orthopaedic surgeon specialising in shoulder injuries) was negligent in not making further enquiries in connection with a radiological report on X-rays which he had requested of the patient. From the X-rays the doctor found no abnormalities and referred the patient to another specialist specialising in injury of the spine. This specialist in turn referred the patient to other specialists. A year later a specialist found that there was a tumour in the patient’s lung, and the specialist could identify this tumour on the X-rays initially requested by the defendant. The defendant was sued for alleged negligence by not requesting a report from the radiologist, who could explain the X-rays to him, and alternatively, that he did not notice the abnormality on the X-rays himself.

The court stated (at 154H):

It is well established that what is expected of a medical practitioner is the general level of skill and diligence possessed and exercised at the time by members of the branch of the profession to which he belongs.

The court pointed out that by the time that there could possibly have been a duty on the defendant to further investigate the radiological report, the patient was already in the care of another specialist, and that such duty no longer existed. Expert evidence was further put forward that the duty to follow up on the radiological report was solely that of the radiologist and that the defendant thus had no duty in this regard. Consequently the court found that the defendant was not negligent in any area in respect of his treatment of the patient.

(c) The “locality rule”

Can the locality where the doctor practises be a factor in assessing whether the doctor has complied with the required standard of skill and care? In the USA the so-called “locality rule” evolved many years ago, whereby the locality indeed played a role. In Van Wyk v Lewis 1924 AD 438 Innes CJ, who delivered the judgment, said that the same measure of skill is required, wherever the doctor may practise:

The ordinary medical practitioner should, as it seems to me, exercise the same degree of skill
and care, whether he carries on his work in the town or the country in one place or another. The fact that several incompetent or careless practitioners happen to settle at the same place cannot affect the standard of diligence and skill which local patients have a right to expect.

Wessels JA however said:

You cannot expect the same skill and care of a practitioner in a country town as you can in a large hospital in Cape Town or Johannesburg. In the same way you cannot expect the same skill in these towns as you will find with the leading surgeons in the large hospitals of London, Paris and Berlin. It seems to me therefore that the locality where an operation is performed is an element in judging whether or not reasonable skill, care and judgment have been exercised.

Wessels JA came to the same conclusion as Innes CJ, namely that the appeal has to be set aside, but he gave his own reasons for his finding, pointing out the above.

South African legal writers generally support the view of Innes CJ, and draw attention to factors such as the standard and uniformity of medical education in the Republic; modern means of communication in the form of professional journals and electronic networks; the general availability of textbooks of a high standard; frequent medical congresses and practical workshops; continuing medical education programmes, and information distributed by pharmaceutical companies about medicine.

Carstens PA “The locality rule in medical practice” 1990 De Rebus 421, however, argued, convincingly that a distinction should be drawn between the subjective abilities (such as skill, education and knowledge) and the objective circumstances in which the accused finds himself in a particular locality. He argued that a lack of medical facilities and infrastructure should be considered in the assessment of his conduct.

We support Carsten’s view. In Collins v Administrator, Cape 1995 (4) SA 73 (C) the court in fact held that when it concerns a claim against a hospital authority for harm suffered by a patient in consequence of the negligence of its staff, a standard of excellence which is beyond its financial resources cannot be expected. In the Collins case a 16-week-old child sustained permanent brain damage because of cerebral hypoxia when a tracheotomy tube which supplied him with air was displaced. It appeared that on account of a shortage of nurses in the provincial hospital a nurse was not near the child at the critical time when he suffered a lack of air. A nurse who then arrived noticed that the child was in distress, but could not manage to replace the tube, and the court held that she had been negligent. (A tracheotomy is an incision into the wind-pipe in order to supply oxygen through a tube.)

(d) Negligence in respect of certain specific harmful results

As has already been mentioned, negligence always has to be determined with regard to the question whether a certain result was foreseeable and preventable. In delictual liability, this result is damage. It is not difficult to imagine how a negligent failure to exercise the required skill and care when diagnosing or treating a patient can lead to damage. Damage may also result from a failure properly to inform a patient. For the purposes of this module, we distinguish between three different cases:

(i) Negligence with regard to damage resulting from inadequate care, knowledge or skill applied when diagnosing or treating a patient
(ii) Negligence with regard to damage resulting from a failure to inform a patient how to behave to protect his or her health

(iii) Negligence with regard to damage resulting from a failure to inform a patient of a risk attached to an intervention

Let us now have a closer look at each of these three cases.

(i) Negligence with regard to damage resulting from inadequate care, knowledge or skill applied when diagnosing or treating a patient

This case is rather straightforward. We illustrate this case with reference to Castell v De Greef 1994 (4) SA 408 (C). The essential facts in Castell were the following: In 1982 Mrs C underwent surgery for the removal of lumps in one breast. In 1989 further lumps were diagnosed. In view of Mrs Castell’s family history her gynaecologist recommended a mastectomy as prophylaxis, and referred her for this purpose to Dr De Greef.

When first consulting Dr De Greef, Mrs Castell and her husband discussed the operation with him at some length. What was proposed was a surgical procedure involving the removal of as much breast tissue as possible, with simultaneous reconstruction of her breasts using silicone implants.

The operation was performed some two months later. Breast tissue was removed bilaterally. A 280 ml prosthesis was implanted on each side behind the pectoral muscle, and the areolae and nipples were repositioned. Complications set in, in the form, inter alia, of discoloration of the skin and a staphylococcus aureus infection. Mrs Castell required medical treatment for a considerable period afterwards, including further surgery, which resulted in medical costs and psychological trauma and pain.

The appeal court found against the doctor on the issue of negligent treatment. It ruled that the patient had proved that she had developed post-operative sepsis in her breasts, of which the doctor became aware, and that the organism, or one of the organisms, causing the sepsis was resistant to the antibiotics which had been prophylactically prescribed by the doctor. The doctor had been negligent in not timeously taking a pus swab and sending it for analysis. Had that been done, an appropriate antibiotic would have been prescribed sooner.

The patient was entitled to be compensated for the additional period – twelve days – of pain, suffering, illness, discomfort and anxiety she had to endure because of the doctor’s failure to treat her infection properly and timeously. Damages in the amount of R7 500 were accordingly awarded and an order of costs made in favour of the patient.

(ii) Negligence with regard to damage resulting from a failure to inform a patient how to behave to protect his or her health

Some information has to be given to a patient to enable him or her to protect his or her health. For instance, a doctor must inform a patient how to behave before, during and after an intervention in order to prevent unnecessary harm or damage. In Dube v Administrator, Transvaal 1963 (4) SA 260 (W) a plaster was applied too tightly to a patient’s fractured arm. The defendant failed to warn the patient to return to the hospital immediately if he should experience any abnormal symptom, and to inform him what the consequences would be if he should fail to do so. Volkmann’s contracture set
in, and ultimately the patient’s arm had to be amputated. The defendant was held liable for his negligent failure to inform the patient.

(iii) Negligence with regard to damage resulting from a failure to inform a patient of a risk attached to an intervention

Could a failure by a doctor to inform a patient in advance of the possible risks involved in a particular medical procedure constitute negligence even if the procedure was not performed in a negligent manner?

In *Castell v De Greef* 1994 (1) SA 408 (C) (which has already been mentioned in (i) above) the court *per* Ackermann J held the opinion that “the issue is treated not as one of negligence, arising from the breach of a duty of care, but as one of consent to the injury involved and the assumption of an unintended risk”. In this case, the court had to consider whether the patient had been adequately informed of the risks involved. It was well known that the operation was attended by a high risk of complications, particularly necrosis of the skin and underlying tissue, including the *areolae* and nipples. As already mentioned, Mrs Castell suffered complications in the form, *inter alia*, of discoloration of the skin and a *Staphylococcus aureus* infection.

On appeal the court found that the patient had been adequately apprised of the inherent risks, particularly those involved in the transposition of her *areolae*. The court also held that the doctor’s failure to quantify the degree of risk – in the form of a complication rate – by mentioning a figure of 50 per cent was not a material nondisclosure. The doctor had therefore complied with the criteria for informed consent laid down by the court. See our discussion of the material risk test in 5.3.4.

In the earlier case of *Richter v Estate Hamman* 1976 (3) SA 226 (C) the court indicated that a failure to disclose the relevant risks could constitute negligence. We are faced with conflicting judgments. What would the correct position be? We should like to submit the following. It is very important to distinguish between the various elements of a delict. See 10.2.3.1 (a) above. If the intervention is performed with the necessary skill and care, the risk does not materialise, and the patient suffers no other harm as a result of the doctor’s failure to disclose the risk, the case should indeed be treated as suggested by Ackermann J, namely as one of consent as a ground of justification. The only damage involved here is the violation of the patient’s personality interests. However, it would be wrong to exclude the possibility of liability based on negligence under any circumstances. (This is also the opinion of Van Oosten FFW “*Castell v De Greef* and the doctrine of informed consent: Medical paternalism ousted in favour of patient autonomy” 1995 *De Jure* 164 at 178.) Suppose the intervention is performed with the necessary skill and care, but the undisclosed risk does indeed materialise. The patient’s health is prejudiced and he or she also suffers substantial patrimonial harm. In such a case the patient should in our opinion be able to succeed with a claim based on negligence. Of course, all the elements of a delict need to be proved. The element of causation is very important in this case. In order to prove a causal connection between the non-disclosure of the risk and the harm or damage, the patient would have to prove that he or she would not have undergone the intervention had he or she been properly informed of the undisclosed risk. If by failing to foresee and prevent this harm, the doctor failed to measure up to the standard of the reasonable health care practitioner belonging to the particular branch of the profession concerned, he or she is negligent. In our opinion, it should be possible to hold the doctor liable under such circumstances.
(e) Proof of negligence

The ordinary rule concerning the burden of proof (onus) is that in a civil action such burden rests with the plaintiff. The case has to be proven on balance of probabilities. Because expert evidence is needed in the overwhelming majority of medical cases, the plaintiff usually finds it difficult to acquit himself of the burden. Often the best the plaintiff can hope for is to find an expert who can interpret for the court occurrences at and in connection with the medical intervention and its consequences. In practice medical practitioners are reluctant to deliver expert evidence in our courts, because of several factors.

(i) Res ipsa loquitur

We draw your attention here to a single factor, namely whether in endeavouring to prove negligence, the plaintiff may rely on the evidentiary principle of res ipsa loquitur ("the thing speaks for itself"). This means that merely by proof of the harmful event and the fact that it was caused by an object which was in the exclusive control of the defendant, a prima facie factual presumption of negligence on the part of the defendant arises. True, the plaintiff will not be relieved of the onus which he bears, but if the defendant does not succeed in offering an acceptable explanation for what happened, the court may readily come to the conclusion that he has been negligent. The principle is often invoked in negligence cases (see Schmidt CWH Bewysreg 3 ed (1990) 163 et seq).

Our courts have displayed a marked unwillingness to apply the res ipsa loquitur doctrine in cases of alleged medical negligence. The leading case is Van Wyk v Lewis 1924 AD 438. Following a surgical operation there was a failure to remove a surgical swab from the patient’s body, with painful consequences. The court refused to find that the doctor was negligent on the basis of res ipsa loquitur. Innes CJ explained the maxim as follows in this case:

Now that maxim means simply what it says – that in certain circumstances the thing – that is the occurrence – speaks for itself. It is frequently employed in English cases where there is no direct evidence of negligence. The question then arises whether the nature of the occurrence is such that the jury or the court would be justified in inferring negligence from the mere fact that the accident happened.

Wessels JA declared in a separate judgment:

The mere fact that a swab is left in a patient is not conclusive of negligence. Cases may be conceived where it is better for the patient, in case of doubt, to leave the swab in rather than to waste time in accurately exploring whether it is there or not, as for instance where a nurse has doubt but the doctor after search can find no swab, and it becomes patent that if the patient is not instantly sewn up and removed from the operating table he will assuredly die. In such a case there is no advantage to the patient to make sure that the swab is not there if during the time expended in exploration the patient dies. Hence it seems to me that the maxim res ipsa loquitur has no application to cases of this kind.

He states a little further on:

The maxim res ipsa loquitur cannot apply where negligence or no negligence depends upon something not absolute but relative. As soon as all the surrounding circumstances are to be taken into consideration there is no room for the maxim. The plaintiff asserts negligence and
bases his claim upon it and this can only be determined by an examination of all the circumstances.

In *Pringle v Administrator Transvaal* 1990 (2) SA 379 (W) a claim resulted from a bronchoscopy (examination of the wind-pipe) followed by a mediastinoscopy (examination of the mediastinum or membrane between the lungs) performed on a 63-year-old woman by a senior registrar, Dr S, who had been employed by the defendant hospital authority. The patient had had a history of carcinoma and had undergone a mastectomy (removal of breast gland) 29 years earlier. She presented with opacity of the right lung, and an investigation of the lung was necessary.

![Diagram of mediastinoscopy](image)

In the course of the mediastinoscopy the patient’s *vena cava superior* (the major vein emptying into the right atrium of the heart) was torn, causing torrential bleeding. The mediastinum was packed in an attempt to stem the blood loss. The patient lost approximately two litres of blood, and a right thoracotomy (a surgical incision of the wall of the chest) was performed to repair the damaged *vena cava superior*. On the day following the operation she went into acute renal failure and required haemodialysis (mechanical purification of the blood).

The patient suffered brain-damage as a result of the operation, and she claimed that this had resulted in permanent damage to her eyesight and permanent inability to work. She also underwent personality and character changes. After the operation her employment was terminated summarily by her employer.

The court found that Dr S had been negligent in tearing the *vena cava superior* while attempting to biopsy the lymph-node in the gland adjacent thereto. In cross-examination it was put to Dr S that he had “tugged” at the lymph-node and pulled the *vena cava superior*. His answer was: “In retrospect I would say that I tugged too hard.”

The judge said that in assessing the foreseeable harm the court must guard against “the insidious subconscious influence of *ex post facto* knowledge”. “Negligence is not established,” she said, “by showing merely that the occurrence happened ... or by showing after it happened how it could have been prevented”.

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She continued as follows:

I am mindful too of all the pressures and the tensions which operate on a surgeon at a time like this. However, in the light of all the evidence and the only possible explanations as to how the perforation of the *vena cava* and the mediastinal pleura occurred, I am driven to find that on this particular aspect, and by using the “excessive force” which he concedes, Dr S did not apply that skill and diligence possessed and exercised at the time by the members of the branch of the profession to which he belonged.

As a result damages in the amount of R92 483 were awarded to the plaintiff. The judgment reaffirmed the view taken in *Van Wyk v Lewis* that there is no room in this type of case for application of the doctrine of *res ipsa loquitur*. Blum AJ observed: “The maxim could only be invoked where the negligence alleged depends on absolutes.”

Van den Heever P *The application of res ipsa loquitur to medical negligence cases: a comparative survey* LLD thesis University of Pretoria (2002) argues that constitutional principles support the extension of the doctrine to this type of case in South Africa.

### 10.2.4 Damage

Apportionment of damages is possible where more than one party is held liable. Suffice it to say that it is possible for a court to order that two parties who are both responsible for the harm, each has to pay a specified part of the damages awarded. In *Wright v Medi-Clinic Ltd* 2007 (4) SA 327 (C) the court ordered on appeal that the doctor who handled the birth during which the plaintiffs’ baby incurred brain damage, has to pay 20% of the damages awarded, and Medi Clinic 80% thereof.

A last aspect in connection with determining damages deserves mention. In *D’Ambrosi v Bane* [2007] 1 All SA 570 (C) the court was *inter alia* requested to decide on the question whether the benefits that a member of a medical scheme receives has to be taken into consideration (ie, deducted) when calculating the amount of damages for costs already incurred and standing to be incurred for future hospital and other expenses due to medical negligence. The court found that the amounts/benefits that a member of a medical scheme receives are not deductible from the claim for real and future hospital and other medical expenses.

### 10.2.5 Causation

**NOTE IN RESPECT OF LANGUAGE:** The words “causation” and “causal” derive from the Latin word *causa* which means “reason” or “cause”. Note the spelling of “causal”. Students frequently write “casual link”. “Casual” means “unconcerned and relaxed”. Whether this common mistake is only a spelling mistake, or whether it evinces a misunderstanding of the concept of causation is not clear.

In our discussion of criminal-law aspects above we said that it is essential to prove a causal connection in respect of materially defined crimes (which include murder and culpable homicide). In study unit 9 we discussed the different tests or theories of causation. Just as in criminal law, both factual and legal causation are required in respect of liability for a delict. In essence the requirements for causation are the same, irrespective of whether the liability is criminal or delictual.
10.2.5.1 Proof of causal connection

As you already know from your study of criminal law and law of delict, factual causation is usually rather uncomplicated, although legal causation which involves considerations of legal policy – might be more problematic. However, in medical law, it is factual causation that is often very difficult to prove. The reason for this is that disease and disease processes can be very complicated and are often influenced by a host of variables. Medicine involves sick people, and substances, procedures and conditions which are not without risks. The plaintiff in these cases almost invariably had some kind of pre-existing ailment which might have led or at least contributed to the harmful result for which damages are sought. A person’s ailment or general ill health might predispose him or her towards the development of certain complications. A diabetic may for instance be expected to be more prone to his or her wounds becoming infected. Risks are attached to most medical interventions and these risks might eventuate despite health care practitioners’ best efforts. The following cases illustrate just how difficult it may sometimes be to prove that the alleged negligent act of the doctor led to the harm for which damages are sought.

In *Pearce v Fine* 1987 (3) *SA Practice Management* 14 (D) the widow of a patient who had died in the course of a radiological examination brought action for damages against radiologists practising in partnership on hospital premises.

The deceased was a 54-year-old male who had experienced problems with micturition. His doctor, suspecting *prostatitis* (inflammation of the prostate gland) referred him to the defendants for a radiological examination of his kidneys, bladder and urinary tract. Such an examination is known as an intravenous pyelograph: while lying on an X-ray table the patient is injected with a chemical substance called a contrast medium. Thereafter X-ray exposures of the area of the body containing the organs mentioned are taken at intervals of approximately five minutes. Contrast medium is injected into the bloodstream so that better pictures of the internal organs may be taken.

The procedure was commenced by G, a radiographer, taking control X-ray photographs for the purpose of comparison at a later stage. Having perused the developed photographs, Dr L injected the contrast medium, after the usual exploration and test dosage. When the solution was injected the patient experienced a hot flush, an strange taste and a feeling of nausea (common reactions experienced by patients undergoing this test). After a few minutes Dr L left the X-ray room. G then proceeded to expose the required series of X-ray films. When this had been done she left the patient and took the X-ray films to the darkroom for processing. The darkroom is approximately eleven paces from the door of the X-ray room. She left the film with the darkroom attendant and returned to the X-ray room.

When G returned, she found the patient unconscious and breathing stertorously, that is with a snoring sound. She hurriedly summoned Dr L and an emergency team from the hospital’s intensive care unit. Resuscitative measures were applied to the patient without success, and he died.

The court accepted G’s evidence that when she left the patient she did so in the *bona fide* belief that his state of health gave no cause for alarm, and that she was absent from the X-ray room for less than two minutes. Dr L testified that when he examined the patient after being summoned by G, he diagnosed cardiac arrest. He immediately started resuscitation procedures. The intensive care team applied defibrillation (delivering an electric shock to “restart” the heart). The very first shock produced normal *sinus rhythm*, but the heart relapsed into ventricular fibrillation (an irregular quivering contraction of the lower chamber of the heart). A second and third shock was delivered with the same result. The fourth shock was to no avail.
Expert witnesses were in agreement on the probable cause of death: the injection had produced a drop in the patient's blood pressure (caused by the patient's anxiety or by the toxic effect of the ingredients of the contrast medium, or by both these factors). The deceased's heart had been unable to pump sufficient blood and had gone into ventricular fibrillation, which could not be effectively reversed.

It was alleged that Dr L had been negligent in that he had left the presence of the patient without satisfying himself that it was safe to do so, or in that he had failed to take steps to ensure that G would remain with the patient until it was safe to leave him. It was further alleged that G had been negligent in that she had left the patient unattended before it was safe for her to do so.

The court found that it was unnecessary to make any finding on the question of negligence. Even if there had been negligence, it had not been established that such negligence was causally connected to the patient's death. On consideration of all the evidence relating to causation, the court was of the opinion that the plaintiff had failed to establish, on a balance of probability, that the patient's life would have been saved had he been kept under constant observation and had resuscitation commenced as soon as he displayed symptoms of distress. There was evidence that the patient's heart had been overweight by some 30 to 80 grams. The fact that the heart is overweight usually means that there is some disease of the heart. An expert witness was of the opinion that the deceased might have suffered from cardiomyopathy, which is a weakness of the heart muscle. There was also some atheroma in the coronary artery. (Atheroma is a deposit of fatty tissue inside the artery, which usually causes some degree of narrowing of the artery.)

There was expert evidence that, all in all, the chances of survival after cardiac arrest are very poor. The experts' experience had not shown that if one could start resuscitation early one could bring the patient round, and he would then survive. Starting resuscitation at the first wave of ventricular fibrillation does not guarantee a successful result. Even under the best circumstances, however early one gets there, one is dealing with a very lethal condition. The death rate where defibrillation is administered within the first four minutes is between 86 and 92 per cent. The difference in the survival rate between treatment in minute one and minute four after

NOTE IN RESPECT OF LANGUAGE:
Another error frequently encountered when marking assignments or examination scripts, pertains to the issue of proof. It is simply wrong to state: "The court could not prove a causal link between the alleged negligent act and the harmful result." The court does not prove anything. In our accusatorial system, the burden of proof lies with the person who alleges something. "The court" refers to the adjudicating officer or officers – the magistrate, judge(s) or judge(s) of appeal, as the case may be – acting in that capacity. "The court" therefore refers to a judge or assembly of judges acting as a tribunal. Having considered all the evidence, the court makes a finding in respect of the question whether the party bearing the onus of proof has succeeded in acquitting himself/herself of such onus. Can you see why it is wrong to state that "the plaintiff/defendant/state/accused held that ..."? "To hold" means the same as "to rule". The verb "hold" therefore signifies an act of ruling on a matter, and "to rule" means "to pronounce authoritatively and legally to be the case". It is also inaccurate to state that "the court alleged" or "the court averred". The parties to a suit "allege" and "aver". The court makes the findings and delivers judgment. "To allege" means to state or affirm something, especially without proof. An averment is a formal statement with offer of proof or substantiation. Therefore, allegations and averments are untested statements. A court does not make the kind of statement that merely claims something or is intended to convince or persuade others. It "pronounces" on the matter in hand, and advances reasons for its judgment (ratio decidendi). When the court makes a statement on a matter that was not necessary to decide upon, it is called an obiter dictum, and such statement does not create a precedent, although it might have persuasive value in subsequent cases.
cardiac arrest is very slight, according to one observer (in the order of approximately 13.5% compared to approximately 6%).

**HINT:** If you were asked in the examination to discuss some cases which illustrate how difficult it is to prove a causal connection between the doctor’s (negligent) act and the dreaded result, you should discuss the cases that we set out here. It is very important that you clearly state that the dreaded result could possibly have other causes. In *Pearce v Fine* the patient possibly had cardiomyopathy, as evidenced by the fact that his heart was too heavy. Furthermore evidence indicated that the chances of survival if defibrillation is immediately started are still very slight. In *Silver v Premier of the Gauteng Provincial Government* there were several risk factors present, predisposing the patient for bedsores. In *Michael v Linksfield Park Clinic (Pty) Ltd* the court found that brain damage would in any case have occurred, even had there been no delay in starting defibrillation. Also note carefully whether the court in all these cases found it necessary to decide the question whether the

This case illustrates how difficult it can be to prove a causal nexus between an alleged medical omission and the death of a patient in some instances.

See also *Silver v Premier of the Gauteng Provincial Government* 1998 (4) SA 258 (W). Here the patient S was admitted to a provincial hospital for treatment of pancreatitis (inflammation of the pancreas). By the time that he was discharged, his ability to walk properly had been permanently impaired. He sued the hospital authority on the basis of alleged negligence which was the cause of a pressure sore (bedsore) which became infected and which resulted in necrotising fascitis (ie death of binding tissue in his body) and ultimately paralysis of the lower limbs. It appeared that S, when admitted to the hospital, was obese, a diabetic, had to be dialysed (ie his blood had to be purified mechanically) – which gave risk to a fluid leak – had a temperature and was hypotensive (ie suffered from low blood pressure).

According to expert evidence on the “constellation” of risk factors predisposing a patient to the development of bedsores, P had a “full house” of these factors.

Evidence was led by the defendant that the standard of nursing care received by P in the hospital had measured up to the required standards. The court came to the conclusion that there had been no proof of a causal connection between any act or omission on the part of the hospital staff. On a balance of probabilities of the case, the sacral bedsore which the patient was likely to have developed would not have remained superficial, and polymicrobial infection would have occurred.

The court (per Cloete J) found as follows:

Assuming, therefore, that the pressure sore on the plaintiff’s sacrum was caused by the negligent omission of the nursing staff in the general surgical ward to give proper pressure part care (a question which I find unnecessary to decide), and assuming further that the plaintiff's
disability resulted from a polymicrobial invasion which spread from the bedsore (a question
which I find unnecessary to decide), the plaintiff is not entitled to the damages which he has
claimed – as, on the probabilities, and given that the plaintiff’s hypothesis as to how his
disabilities occurred is correct, he would have suffered such damages irrespective of any
negligence on the part of the nursing staff in the general surgical ward and, for all practical
purposes, at the same time.

In *Michael v Linksfield Park Clinic (Pty) Ltd* [2002] 1 All SA 384 (SCA) a 17-year-old youngster
underwent corrective nasal surgery after a sports injury. During the operation a too low dosage of
anaesthetic led to the patient going into cardiac arrest. The nurse had some difficulty in operating a
defibrillator in an attempt to normalise the heart. The patient suffered serious and permanent brain
damage. On the facts of the case the court found that even if there had been no delay in the use
of the defibrillator, the brain damage would have been unavoidable. The quantity of cocaine
used in the anaesthetic was within the acceptable limits. There was no negligence on the part of the
anaesthetist. Even if the clinic had instructed its staff properly on the use of the defibrillator, the
timeous use thereof could not have prevented the mishap. (This judgment once again shows that
there is an inherent risk involved in anaesthesia.)

10.3 Liability of a medical practitioner or hospital for the acts
performed by another

Dr Ernest Snyman, a competent and experienced thorax surgeon (works in the
chest cavity) wants to operate on a small boy born with a heart defect. The child
has Hurler syndrome, a genetic abnormality. Due to this abnormality the child’s
oropharynx (upper jaw throat cavity) is blocked by his abnormally large tongue. His
tonsils are also enlarged. His nasal air passage is narrowed through thickening of
the mucous membrane and large adenoids. Administering anaesthesia and
maintaining an open air way is very difficult. His neck is short and stiff. His
mandible joints are also stiff. Furthermore he has certain metabolic problems. Dr
Snyman decides to call in Dr Dozi Dosich, a general practitioner who is interested in
anaesthesia, to administer the anaesthesia. Dr Dosich has problems intubating the
child. The child suffers lack of oxygen to the brain, and extensive brain damage is
caroused. Dr Dosich did not make arrangements for indemnity in respect of
anaesthesia, and as clinical assistant still has a large amount of debt. The
parents of the child want to institute a claim. Could they also claim from Dr Snyman?

A doctor or hospital (X) may sometimes incur liability for the actions performed by another (Y).
Depending on the circumstances, the former’s liability may be based on fault or it may be faultless
liability. Where X’s liability is based on his or her own fault, it is called direct liability. This would be
the case where X did not perform the action on which the claim is based, although he or she is to
blame for the result because of his or her own fault (intention or negligence). An example of this
form of liability is liability based on so-called *culpa in eligendo*, that is, negligence in the choice of an
incompetent, inexperienced, or ignorant assistant or contractor. Where X’s liability is not based on
his or her own fault, it is called faultless liability. Where a hospital or doctor (X) is held liable for an
act performed by another despite the lack of fault on his or her own side, we are dealing with vicarious liability as a form of faultless liability.

10.3.1 Direct liability of a medical practitioner or hospital for the act of another

A medical practitioner or hospital can incur direct liability for the act performed by another if the medical practitioner or hospital

(1) authorises, orders or participates in an illegal intervention. This would be the case if, for instance, a doctor orders a sister to administer an experimental substance to a patient without first having obtained the necessary authorisation for the experiment. See 7.7.2.

(2) makes use of an unskilful, incompetent or inexperienced health care practitioner (eg a radiologist, anaesthesiologist or assistant) while he or she is, or should reasonably be aware of the practitioner’s lack of skill, competence or experience. The practitioner or hospital makes himself or herself guilty of culpa in eligendo by choosing an unskilful, incompetent or inexperienced health care practitioner. The negligence is to be found in the bad choice. In S v Kramer (which we discussed in 9.6.3 above) the court stated that in general neither the surgeon nor the anaesthetist is liable for the other’s negligence, but mentioned that this type of situation constitutes an exception to the general rule.

To establish whether Dr Earnest Snyman could incur liability for the delict committed by Dr Dozi Dosich, it has to be determined if Dr Earnest Snyman’s choice of Dr Dozi Dosich could be said to have been negligent. A strong case could be made that Dr Snyman reasonably ought to have known that the administration of anaesthesia to a child with Hurler syndrome should rather be left to a knowledgeable and experienced anaesthesiologist, and that electing an inexperienced person who is not a specialist anaesthesiologist for this task could amount to negligence. Put differently: Would the reasonable thoracic surgeon have foreseen the possibility that choosing a clinical assistant for administering anaesthesia to a child with Hurler syndrome could cause the child harm, and secondly, would the reasonable thoracic surgeon have taken steps to prevent such harm by choosing a more experienced specialist anaesthesiologist for the task?

(3) intentionally or negligently provides defective medical instruments or equipment to another health care provider who performs a medical intervention.

10.3.2 Vicarious liability

10.3.2.1 Introduction

The principle of indirect or vicarious liability, that is liability for the wrongful act of another by virtue of the doctrine of respondeat superior, is well established in the modern law of delict. The general principle is that there must be a relationship of employment whereby one person (the master or employer) stands in a position of authority vis-à-vis another (the servant or employee) in terms of which the former is legally capable of exercising control over the latter’s actions. The master or
employer will only incur liability for the delict of his or her servant or employee that was performed within the scope of his or her employment. In the past, the right to exercise control was the deciding factor in determining if a relationship of employment existed. Nowadays, the intention of the parties is regarded as the deciding factor. The intention of the parties can be gathered from a variety of facts and factors, and control is but one indication of the existence of a relationship of employment. See Mtetwa v Minister of Health 1989 (3) SA 600 (D) which we discuss in 10.3.2.3 below.

A person is not vicariously liable for the wrongful act of an independent contractor engaged by him or her. Such a contractor undertakes a specific job, and in the execution thereof acts in accordance with his own judgment, in particular as concerns the method applied. He is not a servant but “his own master”. In the medical context the anaesthetist who collaborates with the surgeon performing an operation ordinarily is such an “independent contractor”. (Of course, this rule is subject to the principle of liability based on culpa in eligendo.) The same applies to a specialist to whom a general practitioner refers his or her patient or who is called in on the case. Provided that the surgeon (or general practitioner) on reasonable grounds believes that the anaesthetist (or specialist) is professionally competent to do the job, there is no question of liability on the part of the former. An independently practising doctor who “hires” an operating theatre in a hospital is not an employee of the hospital. The hospital can, therefore, not be held liable for his negligence.

Scapegoat

It has been pointed out above that a medical practitioner or hospital may incur direct liability if they order, authorise or participate in an illegal medical intervention. It is unlikely that a medical practitioner or hospital would authorise the negligent performance of a legal medical intervention. The question of vicarious liability will ordinarily arise in those cases where a person employs another to perform a lawful activity, and the employee then does not proceed with the required or expected measure of skill and care, and causes harm to others. As far as the medical situation is concerned, the potential liability of the doctor for the negligence of his or her professional assistants and the nurses he or she employs is relevant, as well as the possible liability of a hospital authority for the negligence of doctors, nurses, paramedics and other personnel it employs.

We will now take a closer look at the circumstances that may lead to vicarious liability of a doctor and hospital, respectively.
10.3.2.2 Vicarious liability of a medical practitioner

The general requirements for vicarious liability are applicable: a relationship of employment between master and servant must have existed, and the servant must have acted within the scope of his or her employment when the he or she committed delict.

The following guidelines are more concrete and of greater practical value. We distinguish between those instances where a doctor (X) would probably incur liability for the delict committed by another (Y), and those instances where X would probably not incur liability for the delict committed by Y.

(a) Medical practitioner (X) vicariously liable for another’s (Y’s) delict

(1) Partners. One partner (X) is vicariously liable for the wrongful act of another (Y) when such act falls within the scope of partnership business – Lindsay v Stofberg NO 1988 (2) SA 462 (C); Mdeltshe v Litye 1994 (3) SA 874 (E).

(2) Locum tenens who works for a salary. A doctor (X) will incur liability for the delict committed by a locum tenens (Y) if in terms of the agreement between them the doctor takes all the fees and the locum tenens works for a salary.

In any of the above cases the patient may institute a claim against the doctor (X) or the other doctor who committed the wrongful act (Y), or against both.

(b) Medical practitioner (X) not vicariously liable for another’s (Y’s) delict

(1) Partner acting beyond the scope of the partnership practice. Where a partner (Y) commits a delict beyond the scope of the partnership practice, the other partner (X) will not incur liability for Y’s act.

(2) Locum tenens who does not work for a salary. Where a locum tenens (Y) stands in for a doctor (X) and receives all the fees for the service, the doctor (X) will also not be vicariously liable for the actions of the locum tenens (Y).

(3) Anaesthetists, radiologists, professional assistants and nurses. Doctors often make use of the services of other doctors who specialise in a specific area of medicine, such as an anaesthetist or a radiologist. The health care professional (X) who obtains such services from another (Y) will in principle not incur liability for negligent actions by such other health care practitioner (Y). It has been confirmed in our case law that anaesthetists, radiologists, professional assistants and nurses provide their services as independent contractors, and not as servants, employees or agents of the health care professional (X). (See eg Van Wyk v Lewis and S v Kramer). Thus the patient will have to institute a separate action against the anaesthetist, radiologist or nurse who provided his or her services as independent contractor.

10.3.2.3 Vicarious liability of a hospital

The consequences of a simple act of negligence may be of catastrophic dimensions to the patient, and apart from injury to his or her body and disfigurement, may take the form of a substantial patrimonial loss. When that runs into hundreds of thousands – or millions – of rand, the patient’s chances of recovery against a moneyed hospital authority may be far better than against the negligent doctor or nurse, who in legal phraseology may be “a man of straw”. But can a patient sue the hospital instead of the health care professional?
Our courts have on various occasions held both state and private hospitals vicariously liable for the wrongful acts of their staff. The State Liability Act 20 of 1957 expressly provides for delictual liability of the state. Vicarious liability of the state is acknowledged. The Act provides that a delictual claim can be heard by a court if such claim arises out of any wrong committed by a servant of the state acting in his or her capacity and within the scope of his or her authority as such (s 1). In Premier of the Western Cape Province v Loots NO (which we discussed in 10.2.5 above), for instance, the court found that both defendants were liable. The first defendant was the Premier of the Western Cape and was held liable as employer of the second defendant. The second defendant was a clinical assistant at the Tygerberg hospital.

In Mtetwa v Minister of Health 1989 (3) SA 600 (D) the patient had been treated in a hospital in Durban for suspected tuberculosis. The physician who treated her was an employee of the hospital authority concerned. It was alleged that the doctor had acted carelessly in prescribing a particular medicament for her, in consequence of which she suffered a series of unpleasant and harmful after-effects and side-effects. She sued for damages in the amount of R10 000. In his judgment Nienaber J pointed to an earlier principle of law that a member of the professional staff of a hospital was not a “servant proper” for whose misdeeds the hospital could be held liable. The judge stated as follows:

Nowadays, I venture to suggest, the question is purely one of fact. The degree of supervision and control which is exercised by the person in authority over him is no longer regarded as the sole criterion to determine whether someone is a servant or something else. The deciding factor is the intention of the parties to the contract, which is to be gathered from a variety of facts and factors. Control is merely one of the indicia to determine whether or not a person is a servant or an independent worker.

The judge made the following interesting comparison:

Just as, these days, the Minister of Law and Order can be held accountable for the peccadilloes of a policeman even when the latter exercised a discretion of his own, indeed, even if he was not on duty, so too, it might be argued by analogy, the Minister of Health is at risk if a member of the staff of a hospital under his command is negligent in the exercise of any of his duties, be they professional and not subject to dictation from others.

In the event the patient was held to have a legal and valid cause of action.

10.3.2.4 Employer’s right of recovery

An employer (X) who was held liable for the negligence of an employee (Y) acting within the scope of his or her employment is entitled to recover the damages paid to the party who was prejudiced by the negligent employee’s conduct (Z), from the erring employee (Y). The prejudiced party (Z) may, of course, also seek legal recourse against the employee in his or her personal capacity (Y), instead of against the employer (X).

10.4 Indemnity against negligence

May a doctor, hospital or other health-care provider protect him- or itself against liability for possible negligence in treating the patient or for some other form of malpractice by having the patient sign an indemnity form or a so-called “disclaimer” prior to the intervention? You ought to know the answer
to this question by now, since we discussed it fully in 4.1.2 above. Remember that, even though an indemnity clause is a contractual clause, it usually has the import not only to exclude contractual liability, but also delictual liability. Are there any special considerations to be taken into account in the event of an indemnity against delictual liability for an act that caused the death of a patient? In this connection, you are reminded of the *obiter dictum* in *Johannesburg Country Club v Stott* 2004 (5) SA 511 (SCA) which we quoted in 1.3 above. By now you already know that criminal liability for causing the death of a patient cannot be excluded by means of an indemnity clause (see 9.1.2 above).

### 10.5 The cost of litigation and access to justice

Litigation is a costly affair. In fact, it is so costly that many ordinary citizens cannot afford to go to court to enforce their rights. The high cost of litigation is often a strong incentive to settle a claim out of court. The great majority of cases involving medical negligence are settled out of court. Legal practitioners often accommodate a prospective plaintiff by agreeing to charge a so-called “contingency fee”. The Contingency Fees Act 66 of 1997 provides that a legal practitioner may enter into an agreement with a client in which it is agreed that the legal practitioner will not be entitled to any fee for services rendered in respect of proceedings unless the client’s claim is successful. Where the client’s claim does succeed, the legal practitioner will be entitled to a so-called “success fee”. This fee may even be as much as twice his or her normal fee, but may not be more than 25% of the total amount awarded to or obtained by the client in consequence of the proceedings.

### ACTIVITIES

1. Discuss the principles in respect of the standard of care required from doctors, with reference to medical negligence and the burden of proof.
2. Discuss with reference to case law the doctor’s liability if he reveals medical information about a patient to another without the patient’s consent.
3. Name five instances where a doctor may incur liability for the negligent act performed by another health care practitioner.
4. Discuss a number of cases which illustrate how difficult it may sometimes be to prove a causal connection between the medical practitioner’s (negligent) act and the harmful result.
5. Answer the following multiple-choice question: Dr Schuster performs an operation on Adv Harms. She does not inform him of a material risk attached to the procedure. The risk materialises and Adv Harms’ health is prejudiced. He suffers intense pain and incurs very high medical costs as a result of the materialisation of the risk. He feels that his dignity has been violated by her paternalistic attitude. Which of the following statements is INCORRECT?

   (1) Adv Harms can succeed with a claim based on negligence if he can prove that, had Dr Schuster informed him of the undisclosed material risk, he would not have undergone the operation.

   (2) Adv Harms would have to prove that his health was impaired by the materialisation of the risk if he were to base his claim on assault.
(3) Adv Harms would be able to recover patrimonial damages under certain circumstances despite the fact that Dr Harms performed the operation with the required care and skill.

(4) In order to succeed with a claim for satisfaction for the infringement of his physical integrity and dignitas, Adv Harms would have to prove intention on the part of Dr Schuster.

6. Dr Stork performs a Caesarean section on a patient, Mrs Mamabolo, who is pregnant with her first baby. He uses the services of Dr Greene, a general practitioner, who assists at the operation. Dr Greene cuts Mrs Mamabolo’s uterine artery. This necessitates an emergency hysterectomy. Can Mrs Mamabolo institute a claim against Dr Greene and/or Dr Stork?

**FEEDBACK**

1. There are well-established criteria in our law regarding the standard of care required from medical personnel. It is not to be assessed in the light of how the best qualified, most competent practitioner would have acted. Only reasonable care is required. One of the important practical issues regarding the proof of negligence is whether an adverse inference may be drawn merely from the fact that something went seriously wrong, resulting in harm to the patient (res ipsa loquitur). So far judicial pronouncements in South Africa have not favoured application of this doctrine.

2. *Jansen van Vuuren v Kruger*, which sets out the common-law position, has to be discussed. *C v Minister of Correctional Services* and *NM v Smith* has to be discussed to emphasise constitutional protection of the right to privacy. Reference should also be made to *Tshabalala-Msimang v Makhanya* to explain the protection which the National Health Act bestows in respect of the right to privacy.

3. Three of these instances are set out under 10.3.1, and two under 10.3.2.2. A doctor may incur both direct and vicarious liability for negligent acts performed by another health care practitioner.

4. Does this question look familiar? It was raised in our hint under 10.2.5.1. Study the hint carefully, and discuss all three cases.

5. The correct answer is (2), as it is the only incorrect statement.

Option (1): See 10.2.3.2 (d) (iii). This is what constitutes the causal link between the non-disclosure of the risk and the ensuing damage.

Option (2): The harm suffered in the case of assault is the violation of a person’s physical integrity. Any infringement of a person’s physical integrity which is not justified by a ground of justification is wrongful. The undisclosed risk is a material risk. This means that Adv Harms was not properly informed, and that his consent was invalid. Do not confuse infringement of physical integrity (a personality right) with the pain and suffering that can be claimed with the action for pain and suffering.

Option (3): See 10.2.3.2 (d) (iii). Patrimonial damages are recovered by means of the *actio legis Aquilae*. Negligence is sufficient. The circumstances under which such claim will succeed are those in option (1).

Option (4): Intention is required for assault and iniuria.
6. Mrs Mamabolo may indeed institute a claim against Dr Greene. See the discussion of *imperitia culpae adnumeratur* in study unit 9 above. The question would be whether Dr Greene knew or reasonably ought to have known that she lacked the necessary competence to do the surgery. If the plaintiff can prove either negligence or intention on the part of Dr Greene in respect of the performance of a task for which she was insufficiently prepared, she could be held liable in delict. Dr Greene would be blamed for being negligent if she reasonably ought to have known that she might possibly harm the patient because she was not equal to the task. The reasonable person in her position would not have proceeded to perform the surgery. Put differently: the reasonable person would have prevented harm from occurring by refraining from doing surgery unless she was equal to the task. If the circumstances were such that, owing to Dr Greene’s lack of skill and especially experience, Dr Stork ought not to have allowed her to perform the surgery which ultimately led to the hysterectomy, Dr Stork can also incur liability. He would incur direct liability, because his liability would be based on his own negligence. He would be negligent since the reasonable obstetrician would not engage a person who is not equal to the task to perform surgery. He ought to have done the surgery himself or he ought to have made use of a competent assistant. Negligence in respect of the choice of a health care practitioner is known as *culpa in eligendo.*

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**GLOSSARY**

**actio iniuriarum**  The delictual action by means of which satisfaction (*solatium*) is claimed for the wrongful and intentional infringement of a personality interest. (There are certain exceptions to the rule that intention is required – sometimes all that is required is negligence, and sometimes no fault is required.) Pronunciation: “UK-tee-oh in-you-ree-AH-room”.

**antibiotic**  Substance produced or obtained from a micro-organism (especially fungus) which destroys or inhibits the growth of other micro-organisms. Antibiotics are used for treatment of infections caused by organisms which are sensitive for the substance, such as bacteria and fungi; also used to treat infectious diseases. Antibiotics include chrome-amphenicol, penicillin, cephalosporin, streptomycin and tetracycline. Not all antibiotics are effective against all micro-organisms, and it is important to find the right antibiotic for treatment of a specific infection. Antibiotics do not destroy viruses, and are not effective for treating viral infections.

**antigen**  Substance recognised by the body as foreign or possibly dangerous, such as infiltrating bacteria, viruses, poisons, foreign red blood cells, cells of transplanted organs, and even pollen. In response to the presence of the antigen the body produces an antibody to attack and destroy the antigen. An antibody is a type of blood protein produced in the lymph tissue; it circulates in the plasma. Producing antibodies is the basis of immunity and preventing allergic reactions.

**areolae**  Plural form of *areola*, the brownish or pinkish ring around the nipple of the breast.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>assault (delictual)</td>
<td>Wrongful and intentional infringement of a person’s bodily integrity.</td>
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<tr>
<td>atheroma</td>
<td>Degeneration of sides of the arteries due to fatty deposits and scar tissue on the inner layer of the artery. Inhibits blood flow and may cause thrombosis (blood clotting). Predisposes a person to thrombosis.</td>
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<tr>
<td>biopsy</td>
<td>Removal of small piece of living tissue from part of the body or organ for microscopic examination. May also refer to microscopic examination of a sample of tissue obtained thus. Biopsy is an important aid in diagnosing cancer, when a particle of a tumour is examined.</td>
</tr>
<tr>
<td>bronchoscopy</td>
<td>Procedure where bronchi (wind pipes) are examined with a bronchoscope. Two types of bronchoscopes are found: a hard cylindrical tube and a flexible fibre-optic tube with eyepiece and light. Bronchoscope is placed in air passage through mouth or nose. May also be used to obtain samples of bronchial or lung exudations with small forceps.</td>
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<tr>
<td>cardiomyopathy</td>
<td>Chronic defect of the heart muscle (myocardium) with abnormally enlarged, thickened or rigid heart muscle, causing inability to pump blood effectively. May lead to irregular heart beat (arrhythmia) and even cardiac failure.</td>
</tr>
<tr>
<td>cerebral hypoxia</td>
<td>Lack of oxygen in the brain. May be acute or chronic. Effect may vary from minimal (lethargy or torpor) to serious neurological damage (coma, convulsions) and even death.</td>
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<tr>
<td>cocaine</td>
<td>Alkaloid obtained from the leaves of the coca plant or produced synthetically. Sometimes used as local anaesthetic in eye, nose and throat surgery. Constricts small blood vessels where it is applied.</td>
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<tr>
<td>cross-examination</td>
<td>Questioning of the witness of one party by the legal representative (advocate or lawyer) of the opposing party.</td>
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<td>culpa in eligendo</td>
<td>Literally: “Negligence in selection (of a servant).” Negligence incurred by a person who undertook to do something, and then lets someone who is not competent to perform the task, do it. The person making the negligent choice may under certain circumstances incur liability for the harmful action of the incapable servant. Pronunciation: “COOL-pah IN eh-lee-IGHN-dow”.</td>
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<tr>
<td>diabetic</td>
<td>A person suffering from diabetes, any one of a number of metabolic defects leading to abnormally high volumes of urine and unquenchable thirst. When the word is used on its own it usually refers to diabetes mellitus which is abnormal metabolism of carbohydrate characterised by extremely high levels of sugar in blood due to genetic inability to manufacture insulin (Type 1 diabetes) or acquired insulin resistance. (Insulin is important for regulating amount of sugar in the blood.) Diabetes has many long-term complications, such as thickening of arteries, and impairment of retina and kidneys. In lay terms it is said that a person has “sugar”.</td>
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<tr>
<td><strong>dignitas</strong></td>
<td>Dignity. The subjective feeling of dignity or self-respect or the personal sense of self-worth. Infringing a person’s dignity means insulting that person. Pronunciation: “dig-knee-TUSS”.</td>
</tr>
<tr>
<td><strong>dolus directus</strong></td>
<td>The form of intention where the perpetrator in actual fact intends the bringing about of the specific consequence. Also known as “direct intention”.</td>
</tr>
<tr>
<td><strong>dolus eventualis</strong></td>
<td>The form of intention where the perpetrator foresees the possibility that his conduct may result in the consequence complained of, but reconciles him to this fact, ie, nonetheless proceeds with his conduct which leads to the consequence complained of. Also known as “intention accompanied by awareness of the possibility of the consequence”.</td>
</tr>
<tr>
<td><strong>dolus indirectus</strong></td>
<td>The form of intention where the perpetrator has dolus directus in respect of a certain consequence, knowing that another consequence (the one which in fact ensued) will necessarily or inevitably also occur. Also known as “indirect intention” or “intention accompanied with an awareness of the inevitability of the result”.</td>
</tr>
<tr>
<td><strong>fault</strong></td>
<td>The legally blameworthy or reprehensible attitude of a person who acted wrongfully. (Also seen as the blameworthy conduct of a person who acted wrongfully.) Fault manifests in two ways, namely intention (dolus) and negligence (culpa).</td>
</tr>
<tr>
<td><strong>fracture</strong></td>
<td>Total or partial (where the fracture line does not go through the width of the bone) fracture; fracture or crack in a bone, or a tear in cartilage.</td>
</tr>
<tr>
<td><strong>genetic tests</strong></td>
<td>Evaluation of blood, other bodily fluid or tissue for biochemical, chromosomal or genetic markers associated with heredity. Genetics means “the theory of heredity”.</td>
</tr>
<tr>
<td><strong>haemodialysis (dialysis)</strong></td>
<td>Dialysis of the blood. A process where a machine is used to remove poisonous substances and metabolic waste from the blood. Used in the case of kidney failure to perform the blood purification function of the kidneys. The blood flows through a system of pipes from the body to a haemodialysis machine or haemodialysis membrane, which removes the waste products, poisons and extra fluid from the blood. The clean blood flows from there back through a set of pipes into the body. From the Greek: haima (blood) + dia (separate) + lysis (loosen).</td>
</tr>
<tr>
<td><strong>Hippocratic</strong></td>
<td>Refers to Hippocrates, a Greek physician from Antiquity, generally acknowledged as the father of Western medicine. Lived from approximately 460 BC to 370 BC.</td>
</tr>
<tr>
<td><strong>Hippocratic Oath</strong></td>
<td>Oath historically taken by physicians in which they promise to practice their profession in an ethical manner.</td>
</tr>
<tr>
<td><strong>intention</strong></td>
<td>Someone acts with intention when willing a consequence while knowing that this conduct is wrongful. Intention takes three forms, namely dolus directus, dolus indirectus and dolus eventualis. Purpose of will and knowledge of wrongfulness are elements of intention in all three forms.</td>
</tr>
<tr>
<td><strong>locality rule</strong></td>
<td>Rule in terms of which the place where a doctor practices is a relevant consideration when determining what reasonable care, skill, knowledge and judgment entails. The rule thus provides that the place where a doctor practices has to be taken into consideration when considering whether the doctor is guilty of professional negligence. In terms of this rule the same degree of care, skill, knowledge and judgment may for example not be expected of a doctor in a small village than of a doctor in a metropolis.</td>
</tr>
<tr>
<td><strong>lymph node</strong></td>
<td>One of a number of oval structures or “swellings” found intermittently in the lymph vessels (lymph is drained along these vessels). Serve as filters for the lymph, and prevent harmful agents or elements entering the blood. Lymph nodes produce lymphocytes (white blood cells involved in immunity). (White blood cells are the “soldiers” of the body that attack bacteria etc in the blood stream and destroy them where possible.)</td>
</tr>
<tr>
<td><strong>mastectomy</strong></td>
<td>Removal of a breast.</td>
</tr>
<tr>
<td><strong>mediastinoscopy</strong></td>
<td>Procedure whereby an instrument with a light source (mediastinoscope) is inserted under general anaesthesia through a small incision above the sternum (breast bone) into the mediastinum (the space between the lungs behind the sternum.) Enables the doctor to examine organs in the mediastinum, eg the heart and cardiac blood vessels, the lungs, the lymph nodes, the trachea, the oesophagus, and the thymus gland. Mostly done to find cancer or determine the stage of a cancer. Preferred diagnostic tool for lymphoma (malignant tumour of lymph nodes). Biopsy often done simultaneously.</td>
</tr>
<tr>
<td><strong>necrotising fasciitis</strong></td>
<td>Rare bacterial infection of the soft tissue localised in the subcutaneous fatty tissue. Caused by various bacteria, ie <em>Streptococcus pyogenes</em>. Infection spreads within hours or days over the layer of fibrous tissue, destroying the skin, muscle and fatty tissue. If not treated timeously it causes gangrene, tissue necrosis, systemic disease and toxic shock. Life-threatening infection.</td>
</tr>
<tr>
<td><strong>negligence</strong></td>
<td>Perpetrator is negligent when a reasonable person in his or her position would have foreseen the reasonable possibility that his or her conduct could cause harm to another, the reasonable person then taking steps to prevent the advent of the harm, and the perpetrator failing to take such steps.</td>
</tr>
<tr>
<td><strong>non-patrimonial loss</strong></td>
<td>Harmful change in or factual disturbance of a person’s personality interests protected by law, which change does not affect the person’s economic situation.</td>
</tr>
<tr>
<td><strong>oropharynx</strong></td>
<td>Part of the pharynx (throat) between soft palate and top part of the epiglottis (thin, elastic, leaf-like cartilage structure at base of tongue which slides over glottis while swallowing to prevent food or fluids to enter trachea). Glottis is the voice apparatus of the larynx comprising the vocal cords and narrow opening between.</td>
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<td>Term</td>
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<tr>
<td>orthopaedic surgeon</td>
<td>Surgeon specialising in surgical (or non-surgical) treatment of injury and diseases of the bones and adjacent joints, muscles and ligaments.</td>
</tr>
<tr>
<td>pancreatitis</td>
<td>Inflammation of the pancreas, a composite gland producing several hormones and digestive enzymes. Amongst hormones are insulin and glucagon which play an important role in metabolising of sugar; insulin lowers blood-sugar level, and glucagon elevates it.</td>
</tr>
<tr>
<td>patrimonial loss</td>
<td>Calculable monetary loss or decrease in the plaintiff's patrimony (estate) caused by the defendant's wrongful and culpable conduct.</td>
</tr>
<tr>
<td>polymicrobial infection</td>
<td>Infection caused by variety of species of microbe or micro-organisms (organisms too small to be seen by the naked eye, such as bacteria, micro-plasmas, protozoa, rickettsia, viruses and some fungi).</td>
</tr>
<tr>
<td>privileged occasion</td>
<td>Ground of justification in a defamation or invasion of privacy action which justifies the <em>prima facie</em> wrongfulness of the defendant's conduct where the defendant has a right, obligation or interest to make certain allegations, and the person or persons to which the allegations are revealed have a similar right, duty or interest to hear these allegations.</td>
</tr>
<tr>
<td>prophylactic</td>
<td>Protective or preventative (especially in respect of illnesses).</td>
</tr>
<tr>
<td>prostatitis</td>
<td>Inflammation of prostate gland. Common medical condition in adult males, caused by bacterial infection. Symptoms include impeded ability to urinate</td>
</tr>
<tr>
<td>quantum</td>
<td>Literally: “amount”. Refers to amount of damages or compensation (<em>solatium</em>).</td>
</tr>
<tr>
<td>res ipsa loquitur</td>
<td>Literally: “the matter speaks for itself”. The maxim from the law of evidence justifying a presumption of negligence in certain circumstances. When this maxim is applied there is a <em>prima facie</em> factual presumption of negligence, or an admissible presumption of negligence on the side of the defendant is made as soon as the mere fact of the harmful events and the fact that they were caused by an object under the sole control of the defendant, are proven. The maxim does not affect the burden of proof. The plaintiff is thus not relieved of the burden of proof, but if the defendant cannot give an acceptable explanation of the events, the court may conclude that the person was negligent. Therefore there rests a burden of rebuttal on the defendant, which entails that he or she has to bring evidence that the facts may also be interpreted to mean he or she was not negligent. The defendant thus has to bring evidence that creates reasonable doubt. Pronunciation: RAYS IP-suh LOCK-wee-toor.</td>
</tr>
<tr>
<td>respondeat superior</td>
<td>Literally: “let the master answer”. A common-law doctrine in terms of which the employer is liable for employees’ conduct which falls within the scope of their employ. Pronunciation: res-pon-dee-UT sue-pē-ree-OR.</td>
</tr>
<tr>
<td>resuscitation</td>
<td>Measures aimed at helping person regain consciousness.</td>
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<td>Term</td>
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<tr>
<td>sacral bedsore</td>
<td>An ulcer in the sacral region caused by pressure and poor circulation in the affected area. Occurs mostly in people who are emaciated, obese, immobile or diabetic, or who suffer from an impaired circulation. The sacral area is found near the sacrum, the triangular bone at the basis of the backbone just below the lumbar vertebrae above the coccyx and between the hip bones.</td>
</tr>
<tr>
<td>sepsis</td>
<td>Presence of pathogenic (which causes illnesses) micro-organisms or their poisons in the blood or tissue.</td>
</tr>
<tr>
<td>silicone implants</td>
<td>Surgical placing of a silicone prosthesis (sack filled with silicone) in the breast as reconstruction after mastectomy. Also used in plastic surgery to enlarge breasts.</td>
</tr>
<tr>
<td>sinus rhythm</td>
<td>Normal heart rhythm. There are various criteria for a normal sinus rhythm: it indicates that the impulse is normally created in the sinus node, moves through the heart in a normal manner, and that the heart rate is within the normal limits.</td>
</tr>
<tr>
<td>staphylococcus aureus infection</td>
<td>Infection caused by a pathogenic species of <em>Staphylococcus</em>. Abscesses of the skin or any other organ are typical.</td>
</tr>
<tr>
<td>swab</td>
<td>Small piece of absorbent material. During operations gauze swabs are used to absorb blood from around the operation area. These swabs must be counted to ensure that none is left behind in the patient. At present radio-frequency labelling is used to mark swabs and prevent some being left behind.</td>
</tr>
<tr>
<td>thoracotomy</td>
<td>Incision into and surgical opening of the thorax (that part of the body cavity between the neck and the diaphragm) to operate on or merely view the heart, lungs or other structures.</td>
</tr>
<tr>
<td>thrombosis</td>
<td>Forming or presence of a blood clot (thrombus). Thrombosis in an artery inhibits or blocks blood flow to the relevant organ. Eg, if the thrombus blocks an artery supplying the brain, it causes a stroke; if it blocks an artery supplying the heart (coronary thrombosis), it causes a heart attack (myocardial infarct). Thrombosis may also occur in a vein. If the thrombus disengages from its origin, is transported in the bloodstream and affixes itself somewhere else, an embolism is formed.</td>
</tr>
<tr>
<td>tracheotomy tube</td>
<td>Rubber, metal or plastic tube attached to the stoma (artificial opening in throat) after a tracheotomy. A tracheotomy is a surgical procedure where a hole is made in the neck through the trachea (wind pipe) to relieve obstruction in the airway and ensure proper air flow.</td>
</tr>
<tr>
<td>tumour</td>
<td>Abnormal swelling. Term is normally used to refer to a new and abnormal growth (neoplasm) where cell growth is uncontrolled and progressive, and the growth performs no physiological function. May be malign or benign. Malignant tumour (cancer) invades and destroys the tissue where it originates, and spreads via the bloodstream and lymph system to other sites in the body (metastasises). If not treated it leads to progressive degeneration and death. Benign tumour does not invade the tissue where it originates, and does not metastasise to other parts of the body.</td>
</tr>
<tr>
<td>Term</td>
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<tr>
<td>vena cava superior</td>
<td>There are two <em>venae cavae</em> in the body, namely the upper <em>vena cava</em>, or superior <em>vena cava</em>, and the lower or inferior <em>vena cava</em>. The upper <em>vena cava</em> drains blood from the head, neck, thorax and arms.</td>
</tr>
<tr>
<td>vicarious liability</td>
<td>Faultless liability of one person for another’s wrongful conduct. Thus liability where one party is indirectly made faultlessly liable through harmful conduct of another. A special relationship between the two parties is a prerequisite for vicarious liability. The type of relationship relevant in the present context, is that between an employer and employee.</td>
</tr>
<tr>
<td>Volkmann’s contracture</td>
<td>Serious and permanent contraction of the forearm and hand caused by ischemia (insufficient blood supply). Pressure injury in the area of the elbow usually precedes this condition, and the pressure caused by a plaster of Paris cast is also a common cause. Causes the hand to become claw-like.</td>
</tr>
</tbody>
</table>
STUDY UNIT 11

Infringing the right to decide on reproduction

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Activities
Feedback
Glossary

Learning outcomes

When you have completed this study unit, you should be able to

- define the concepts of wrongful pregnancy/conception, wrongful birth, and wrongful life
- differentiate between the above concepts
describe the factual circumstances in respect of the different causes of action relevant to the above concepts
explain whether a defendant in a set of facts can incur liability in respect of the different causes of action referring to the concepts above
discuss the reasons for accepting or rejecting, as the case may be, the specific cause of action by our courts
determine whether the claim relevant to the cases discussed was based on a contract or a delict
explain whether patrimonial and/or non-patrimonial loss may be claimed in a particular set of facts
decide whether a request for sterilisation because of socio-economic circumstances is a relevant consideration in respect of a claim for wrongful pregnancy where the claim is based on
  – contract
  – delict

11.1 Introduction

Failure to act with the necessary care to fulfil people’s wishes in respect of reproduction may sometimes lead to civil liability, either because of breach of contract, or on the grounds of a delict. Doctors, hospitals, pharmaceutical companies who manufacture contraceptives, pharmacists and genetic counsellors are all subject to the risk of these types of claim. We have seen that the Constitution guarantees every person’s right to make decisions concerning reproduction (see 1.4 above). We have also seen that both sterilisation and abortion are regulated by law, and that these interventions thus will be legal in certain circumstances.

It stands to reason that doctors play an important role in sterilisation, the termination of a pregnancy, and contraception in general. Sometimes they are approached by a couple who want to have a child, and need advice on the risks of genetic diseases being transmitted to the child. Part of proper prenatal care of pregnant women is to examine the state of the foetus, and inform the parents of the wellbeing, or not, thereof. Parents who are duly informed of any possible abnormality or disability in the unborn foetus are able to decide, within the boundaries of the law, whether they want to abort the foetus rather than continue with the pregnancy. Doctors are also involved in performing sterilisations, and in all legal abortions after the twelfth week of the gestation period. They also often give advice on contraceptives, and prescribe these.

A person’s wishes in respect of reproduction may be denied if a doctor does not duly fulfil these duties. The result of such infringement of a person’s right to decide on reproduction is that a child may be born that would not have been born had it not been for the doctor’s conduct (act or omission). Of course, the fact that a child was unwanted does not mean that the parents do not love the child once it is born. However, it remains a fact that the parents of such a child is burdened with specific expenses – including a duty of maintenance – which they could legally have avoided. If they would indeed have avoided the expenses had it not been for the doctor’s conduct, the doctor may, in certain circumstances, be held liable for such expenses.

In this study unit we discuss three causes of action or types of action which result from infringement of a person’s right to decide on reproduction, or frustration of such decision that has already been taken. These causes of action are wrongful pregnancy/conception, wrongful birth, and wrongful life.
11.2 Definitions

Up to now legal terminology in respect of the causes of action which we discuss in this study unit has not taken a fixed form. Although there is considerable criticism against the terms we use below, they are fairly commonly used in legal literature, both in South Africa and internationally. They have also been used by Goldblatt J in *Friedman v Glicksman* 1996 (1) SA 1134 (W) 1138 to differentiate between the different causes of action. The terms we use below are often used to differentiate between the three causes of action, although the precise content of what falls under each cause differs from one source to another. By defining the meaning of each term we have considered the different situations that have been decided in South African courts.

(1) **Wrongful pregnancy/conception** refers to cases where the parents (or parent) of a healthy but unwanted child institute a claim against the party who allegedly is responsible for failing to prevent the conception of the child or the mother’s pregnancy.

(2) **Wrongful birth** refers to cases where the parents (or parent) of a disabled or handicapped child institute a claim against the party who allegedly is responsible for failing to prevent the birth of the child.

(3) **Wrongful life** refers to cases where a disabled or handicapped child him- or herself, or the parents (or parent) of such child institute a claim on behalf of the child against the party who allegedly is responsible for failing to prevent the birth (life) of the child.

We will now discuss these three causes of action.

11.3 Wrongful pregnancy

11.3.1 Introduction

Mr Virilios Papadopoulos, a divorced man, meets the real love of his life, Mrs Baby Poppins, after many years. She is a widow with six children who are still under her care. Mr Papadopoulos is not what one would call rich – his supermarket went bankrupt during the big recession. However, the love between the two is flourishing. Mr Papadopoulos makes some serious advances to Mrs Poppins, but Mrs Poppins wards him off. It is not as if she does not fancy him, she explains, but she certainly does not want any more children, and she stopped taking the pill years ago. Mr Papadopoulos assures her that he had a vasectomy, done by Dr Tube-Tucker, a urologist. Nine months and ten minutes later Mrs Poppins gives birth to a healthy baby boy, Poulos. What is the possibility that Papadopoulos and Poppins will succeed with a claim against Dr Tube-Tucker for financial support for their precious little darling?

These days contraception is common practice, and is in fact regarded as an important way to counteract the problems of overpopulation. It is imperative in view of the fact that the world population now exceeds seven billion, and resources are becoming increasingly scarce. (Of course
respect should be paid to those people who are against contraception on religious grounds.) As we have seen in 8.1 sterilisation is legally permissible. Although the courts initially were unwilling to concede to claims such as the one in our scenario, it is a fact that such a claim will succeed if the normal requirements for liability are met.

11.3.2 \textit{Behrmann v Klugman} 1988 (W)

The first decision on “wrongful conception” in South Africa was \textit{Behrmann v Klugman} 1988 (W). This case has not been reported, but was discussed by Strauss in 1988 (4) \textit{SA Practice Management} 6. In that case Mr and Mr B sued Dr K, a specialist surgeon, for a total of R299 609 damages in consequence of the birth of a normal child who had been conceived following a \textit{vasectomy} performed by the doctor on Mr B. The plaintiff’s action was based on alleged breach of contract on the part of the doctor, and alternatively, negligence (delict). The plaintiffs alleged \textit{inter alia} that there had been an express or implied agreement that the doctor would properly and skilfully carry out the vasectomy, taking all necessary precautions to ensure that the vasectomy rendered Mr B permanently sterile, and to prevent \textit{recanalisation of the vas deferens} (sperm duct). It was contended by the plaintiffs that the doctor had failed to advise Mr B to have a \textit{sperm count} before intercourse without contraception was resumed. The doctor denied that he had breached the agreement or had been negligent.

The decision in the \textit{Behrmann} case essentially turned on whether the plaintiffs had been adequately warned about the necessary \textit{sperm counts} in order to establish infertility. The plaintiffs testified that statements made by the doctor had caused them to believe that the operation was
irreversible and would render Mr B sterile after ten weeks. Dr K testified, however, that it was his practice to tell patients that it would take up to nine months to achieve two negative sperm counts, and that he would first have to declare the husband sterile. Melamet J found in favour of the doctor. The judge found on the evidence of the plaintiffs that they had in fact waited sixteen to twenty weeks after the operation before commencing intercourse without contraceptives. Accordingly the judge had grave reservations whether Mr and Mrs B had in fact believed that Mr B would be sterile after ten weeks.

The court agreed with the view expressed by the English Court of Appeal in *Eyre v Measday* that in the absence of an express warranty the court should be slow to imply that a medical man gives an unqualified warranty regarding the results of an intended operation. Melamet J concluded that Mr and Mrs B, on a balance of probabilities, had failed to establish that the contract between them and Dr K contained an express or implied term or warranty regarding the permanent success of the operation.

In view of the grounds on which the plaintiffs’ claim was rejected, the decision leaves the question begging whether such a claim is not contra bonos mores.

### 11.3.3 Edouard v Administrator of Natal 1989 (2) SA 368 (D)

In a comparable case, *Edouard v Administrator of Natal* 1989 (2) SA 368 (D), the verdict went in favour of the parents of a child. In that case the parents had agreed with a provincial hospital that a Fallopian tube ligation would be performed on the woman at the time of giving birth by Caesarean section to her third child. The hospital staff failed, however, “to cause the said surgery to effect the tubular ligation of the [woman’s] fallopian tubes, to be performed at all”.

The woman and her husband believed that the sterilisation procedure had been performed, and accordingly took no precautions to use any contraceptive methods to prevent pregnancy. Approximately four months after the birth of her third child the woman fell pregnant again. She
gave birth by Caesarean section to a normal child, and a tubal ligation was then performed on her by Dr F.

The child’s father brought action against the Provincial Administrator in his capacity as the executive of the Provincial Administration for damage allegedly suffered in consequence of breach of contract. The defendant conceded that the administration was liable for damages for breach of contract as a result of its failure to effect the tubular ligation that had been agreed upon, and contended that payment of the cost of the surgery (R622,79) subsequently performed by Dr F would discharge its liability. A factor in this case, it is to be noted, was that the defendant had also conceded that the woman had requested the procedure because she and her husband could not afford to support any more children.

The plaintiff, however, averred that he was entitled to receive further compensation, namely:

(1) for the discomfort, pain and suffering, and loss of amenities (non-patrimonial damages) suffered by his wife (with whom he was married in community of property and on whose behalf he sued)
(2) the cost of maintaining the child until she attains the age of 18 years (patrimonial damages).

The defendant denied liability for such further compensation on the grounds that although the contract for the woman’s sterilisation was valid and enforceable, it would be contrary to public policy to allow the parents of a healthy and normal but unplanned child to recover the cost of bringing up the child where the parents refuse to give the child out for adoption.

Council for the defendant argued that it was the notion that the court, in assessing “damages” of this nature, was called upon to decide whether a value or no value in monetary terms should be given to a healthy life, an action that was offensive in the light of the South African view of the sanctity of life “in the context of our anti-abortion laws”. The cost of maintaining a child, it was submitted, was “but one of the incidents of parenthood – that Pandora’s box of joy, expectation, disillusionment, worry, expense and resignation and hopefully, in old age, reward”.

The court held, however, that damages in the form of maintenance for the child were recoverable. Sterilisation, according to the judge, has become an accepted form of contraception for married couples. “It is in the interest of society that the size of a family should not exceed the limit beyond which it would not be possible to maintain a reasonable standard of living.”

The judge went on to say that there would be nothing inconsistent in the attitude of the parents if they were to say that they had not wanted another child, but now that the child had been born, they loved it and refused to part with it. The acceptance of the responsibilities of parenthood, however, would still leave the parents in the dilemma which they had wanted to avoid by means of the sterilisation, that is that they have a child whom they are unable to support.

The loss which the parents complained of was an economic loss which cannot and need not be weighed against the value of the life of a child. The emotional benefits which the birth of the child bestowed on the parents do not increase their patrimony, and are irrelevant in the determination of the quantum of damages.

Thirion J continued as follows:

It would be fair and equitable that liability to provide for the maintenance of a child should fall on the doctor through whose neglect it was born, rather than that it should fall on the parents, who because of their inability to provide adequately for the child had not wanted to have it. Fathers
are regularly ordered by the courts to bear the cost of maintaining their illegitimate offspring. It would be a novel argument for the father of such a child to claim that by fathering a child he had conferred a benefit or a blessing on the mother which outweighs the cost of maintaining the child.

The court regarded the argument that it is morally wrong that a normal healthy life should be the basis of a compensable wrong as “squeamish and pedantic”. Compensation would not be awarded for the fact that a child was allowed to be born. It would be awarded for the loss which the parents would suffer in having to support the child whose conception the doctor had negligently failed to avoid, and whom they would not be able to support.

No court would require parents to mitigate their loss by having the child adopted. An innocent party who has suffered loss as a consequence of breach of contract had only to take reasonable steps to mitigate his loss. To require that parents should give away their child would not be reasonable. That would run counter to our accepted community values.

The judge felt that although the assessment of damages in wrongful birth actions can raise difficulties, those difficulties are not by any means insurmountable.

The fears that imposition of liability would lead to awards of damage quite disproportionate to the moral culpability of the doctor, or might tend to warp professional standards in that doctors might be tempted to improperly advise patients to have abortions or make practitioners unwilling to undertake sterilisation operations, were exaggerated in the judge’s opinion. He added that the operation is a fairly simple procedure, and that it would be a simple matter for the doctor to explain to the patient that there is, despite the operation, a possibility that she might still fall pregnant. It would be easy for the doctor to contract out of liability.

In the event the court came to the conclusion that it would not be contrary to public policy to recover damages in respect of the child’s maintenance. The defendant was accordingly ordered to pay R22 500 to the plaintiff, the amount on which the parties had agreed.

The court was not prepared, however, to award general damages for the woman’s pain and suffering, etc. “The question whether liability on contract for damages should be extended so as to cover damages for non-pecuniary loss flowing from the breach of the contract, involves considerations of legal policy,” the judge said. In view of the ease with which a delictual claim can be conjoined with a contractual claim, the judge saw no real need for extending liability to contract for that kind of loss. In this case a delictual claim was not so conjoined.

If you read the decision yourself, you will see that the court in this case used the expression “wrongful birth” for the sake of convenience, although, according to our definitions, it should have been a case of wrongful pregnancy/conception.

11.3.4 Administrator of Natal v Edouard 1990 (3) SA 581 (A)

Edouard's case was taken on appeal and the judgment of the court a quo was confirmed unanimously by a five-judge bench of the Appellate Division in Administrator of Natal v Edouard 1990 (3) SA 581 (A). In his judgment Van Heerden JA drew attention to the fact that the case was unique in the sense that it was based upon a complete failure to perform a sterilisation.
procedure as agreed upon. As far as terminology was concerned the judge preferred the simpler designation of a “pregnancy” claim.

The Appellate Division dealt at length with the argument that as a matter of law the birth of a normal child is such a blessed event that the benefits flowing from parenthood cancel or outweigh the financial burden brought about by the obligation to maintain the child. It was argued before the court that the birth of a normal child cannot be treated as a wrong against his parents. The judge said that the concise answer to that “is that the ‘wrong’ consists not of the unwanted birth as such, but of the prior breach of contract (or delict) which led to the birth of the child and the consequent financial loss”. Van Heerden JA made the following observation:

I do not find attractive the proposition that the birth of a normal child is a blessing which in law cannot constitute a wrong. Parents who cannot afford a further child may well be overjoyed by the birth of another, but unwanted, sibling, but will naturally be dismayed by the additional financial burden cast upon them. It is, after all, that burden and not the child as such which is unwanted.

He said that the birth of a normal child does not invariably constitute a blessing, and that “the child may turn out to be a drug addict or violent psychopath”.

The court also responded to the argument that it would be highly undesirable for a child to learn in his later life that a court had publicly awarded damages to his parents because his birth was a mistake. On this Van Heerden JA had the following to say:

Once parents decide to keep the child and not to put him out for adoption, the child is no longer unwanted. What remains unwanted is the additional financial burden caused by his birth. Should the child learn that his birth was a mistake, what will matter to him is not why he was born, but how his parents subsequently cared for him.

The main submission of counsel for the appellant was that it was against public policy that the basic legal duty of parental support be transferred to the hospital authority. This, it was argued, would interfere with the sanctity accorded by law to the parent-child relationship. The Appellate Division regarded his contention as basically fallacious. The judgment in favour of the child’s father – in so far as the sum of R22 500 was awarded – in no way relieved himself or his wife from the obligation to support the child. Accordingly there was no transfer of that obligation. Should the money be lost for some reason, the father would remain obliged to support the child “from such other sources as he may be able to muster”.

The court therefore found that the father’s pregnancy claim had rightly been allowed by the court a quo. An important qualification was added to this finding by the court, namely that this conclusion was “intended to pertain only to a case where, as here, a sterilisation was performed for socio-economic reasons”. As far as the father’s claim for damages for discomfort, pain and suffering, and loss of amenities of life experienced by his wife in consequence of her pregnancy and confinement was concerned, the Appellate Division also confirmed the judgment of the trial court that an intangible loss cannot be recovered in contract. Only patrimonial loss may be recovered.

The Edouard decision leaves little doubt that in South Africa liability will arise in the “classical” situation of “wrongful conception” (pregnancy resulting from medical negligence in respect of sterilisation where a normal child is born). This case also
prepared the way for acknowledgment of a “wrongful birth”, that is where it is alleged that the birth of a handicapped child should have been medically prevented by means of, for example, a lawful abortion.

11.3.5 Mukheiber v Raath 1999 (3) SA 1065 (SCA)

Before ending our discussion under this heading, reference should be made to an unusual South African case in which a doctor was sought to be held liable on the basis that he had made a misrepresentation relating to the sterilisation of a woman.

In this case a married woman and her husband claimed damages from a gynaecologist after the woman had given birth to a normal child. The allegation was made that the doctor had delivered the woman’s previous child by means of Caesarean section, and when he removed the operation stitches shortly afterwards, told the woman and her husband that he had performed a sterilisation operation on her. (The doctor, when removing the stitches, allegedly told the woman that she was now a “sports model”.) As a result of the doctor’s statement the couple did not use contraceptives, and another child was conceived and born in due course.

It was common cause that a sterilisation was never done by the doctor. It was further common cause that when the Caesarean section was decided upon, the question of the doctor performing a sterilisation upon the woman was discussed. The doctor advised her to discuss this matter with her husband, as he regarded the latter’s consent as necessary. No discussion as proposed by the doctor took place, however, and it was never agreed by the parties that Dr M would perform a sterilisation procedure. In court Dr M denied that he had ever told Mrs R and her husband that he had sterilised her.

On the evidence before it the Cape High Court found that the plaintiffs had not proven that the doctor had made a misrepresentation. However, an appeal to the full bench of the Cape High Court succeeded. Since the question of sterilisation originally arose because of the plaintiffs’ financial inability to afford further children, the court held that the plaintiffs were entitled to recover damages.

The doctor brought an appeal to the Supreme Court of Appeal, which upheld the decision of the full bench. This court ruled that the plaintiffs were entitled to be compensated by the doctor for a pure economic loss, in respect of (a) confinement costs, and (b) maintenance of the child until it becomes self-supporting. The court further made the following important statement: In a delictual action of this nature, the claim for damages is not limited only to the situation where the request for sterilisation was made for socio-economic reasons (par 48 of the judgment).

Can a doctor protect himself against this form of liability by insisting that the parents of the child pre-operatively sign a disclaimer (waiver) agreement? (This is done generally in practice today.) In Edouard (1989 (2) SA 368 at 385E) the court obiter seemed to suggest that it was possible. But Edouard’s case did not pertain to negligence; the claim was based on breach of contract. The question to be answered is whether an indemnity against liability for negligence will not be contra bonos mores. See our discussion in 4.1.2 and in particular 4.1.2.1.
11.3.6 Conduct which may lead to a claim for wrongful pregnancy

A doctor or genetic counsellor who gives a couple the wrong advice on their chances of having a disabled child, deprives the couple of the choice to rather prevent the pregnancy than to take the risk of conceiving a disabled child. If the couple then does not prevent pregnancy, it is to our mind a case of **wrongful pregnancy**. The possibility then exists that even would the child be born and it is not disabled, the doctor or genetic counsellor may incur liability.

Other conduct which may lead to this type of claim is:

- failure to perform an agreed sterilisation
- failure to perform a sterilisation properly so as to result in infertility
- misrepresentation that a sterilisation was performed, while it was in fact not done
- false assurance that a patient (either before or after sterilisation) is infertile

11.4 Wrongful birth

11.4.1 Introduction

In **Friedman**, the plaintiff, a woman, alleged that the defendant, a gynaecologist, had negligently failed to diagnose a severe defect in her unborn child and to advise her to have her pregnancy terminated. The court held that the plaintiff was entitled to recover damages in this case. This case concerns abortion and not sterilisation. Liability on the grounds of wrongful birth may apparently also arise because of sterilisations being either negligently performed, or not performed at all.

11.4.2 Friedman v Glicksman 1996 (1) SA 1134 (W)

The first South African decision on “wrongful birth” and “wrongful life” was handed down in the case of **Friedman v Glicksman** 1996 (1) SA 1134 (W). In this case the plaintiff, Mrs F, gave birth to a disabled child, Alexandra. In suing Dr G, Mrs F made the following allegations: When pregnant, she consulted Dr G, a specialist gynaecologist, to advise her apropos the risk that she might have been pregnant with a potentially abnormal and/or disabled infant. It was understood between Mrs F and the doctor that she wished to terminate the pregnancy if there was any risk greater than the normal risks of the infant being born in an abnormal and/or disabled condition.

The agreement was that the doctor would provide such advice in order that Mrs F might make an informed decision on her own behalf and on behalf of the unborn child, whether to terminate the pregnancy or not. Alternatively it was alleged by Mrs F that Dr G, by virtue of his professional status, had a duty to provide the advice to her in her personal capacity and on behalf of the unborn child for the purpose of making the decision on possible termination.

The doctor, Mrs F alleged further, had carried out certain tests and advised her that there was no greater risk than the normal risk of having an abnormal and/or disabled child, and that it was quite safe to proceed to full term to give birth. His advice, she said, had been erroneous and Alexandra was born disabled. She maintained that in giving this advice, Dr G had acted negligently in a number of respects. Had she received the correct advice, she said, she would have terminated her pregnancy forthwith. She accordingly brought two claims: a claim on the grounds of wrongful birth,
which we will discuss here, and a second claim on the grounds of wrongful life which we will discuss in 11.5.

The mother’s claim for wrongful birth was a claim in her personal capacity for the expenses of maintaining and rearing Alexandra, as well as for all future medical expenses and hospital treatment and other special expenses.

The doctor argued that it would be against public policy to enforce the contract entered into between Mrs F and himself, “because it would encourage abortion and thus be inimical to the right to life enshrined in the [interim] Constitution … as well as to the generally recognised sanctity accorded by society to life and the process by which it is brought about”. The judge rejected this argument, though, pointing out that it was contrary to the Abortion and Sterilisation Act 2 of 1975, then in force, which allowed abortion inter alia in cases where there was a serious risk that the child to be born would be irreparably seriously handicapped, either physically or mentally.

Goldblatt J went on to say:

Thus the legislature has recognised as do most reasonable people, that cases exist where it is in the interests of the parents, family and possibly society that it is better not to allow a foetus to develop into a seriously defective person causing serious financial and emotional problems to those who are responsible for such person’s maintenance and wellbeing. However, it must be stressed that the election to proceed with or terminate the pregnancy in these circumstances rests solely with the mother who bears the moral and emotional burden of making such election.

In the judge’s view the contract entered into between Mrs F and Dr G was “sensible, moral and in accordance with modern medical practice”. “Wrongful pregnancy” and “wrongful birth” claims are therefore not contrary to public policy. The doctor’s argument that there could be no claim against him since Alexandra’s condition had not been caused by an act or omission on his part but was a congenital defect arising at the time of conception, could not stand, the judge ruled. The claim is based on the fact that but for the negligent advice, the plaintiff would have had her pregnancy terminated. Thus the doctor is responsible and caused the child, with her disabilities, to be born. Once proper disclosure of the risks is not made and the woman is deprived of her option, “the damages she has suffered by giving birth to a disabled child are clearly caused by the fault of the doctor, provided she would have terminated the pregnancy if the information had been made available to her”. In upholding the claim for “wrongful birth”, the court relied inter alia on the Edouard case (supra).

11.4.3 Sonny v Premier, Kwazulu-Natal 2010 (1) SA 427 (KZN)

In Sonny v Premier, Kwazulu-Natal 2010 (1) SA 427 (KZN) wrongful birth as cause of action once again came up for discussion. In brief the facts are the following: During her pregnancy the woman, originally a patient of the Clare Estate Clinic, was referred by the clinic to the Addington hospital (headed by the first defendant, the Premier) for an ultrasound scan. The results of the scan were inconclusive, and neither a positive or negative deduction could be made. The hospital referred the woman back to the clinic to make an appointment for a follow-up scan in two weeks at the Addington hospital. On return to the clinic she received the wrong information, namely that the report on the first ultrasound scan indicated that everything is normal. (On expert evidence during the trial it however transpired that, although the report was not conclusive, it did in fact indicate the risk of
Based on this wrong information the woman did not return to the Addington hospital for a second ultrasound scan. Four months later she was again referred by the clinic to the Addington hospital for a second scan, after which a cordocentesis test was done to test the baby for Down syndrome. The test indicated that the baby was normal. Only after the baby was born by way of a Caeserean section it was discovered that it indeed had Down syndrome.

The first claim: The husband and wife (as first and second plaintiffs) brought a claim on the grounds of wrongful birth, for damages flowing from the birth of their child with Down syndrome. The claim was instituted for both breach of contract and delict. The plaintiffs alleged that the professional medical staff, whose duty it was to monitor the woman’s pregnancy, did not fulfil their obligations. They failed to do the required tests in an early stage to determine whether the foetus had any genetic abnormalities. The woman was in the high-risk category, and her age alone (37) justified a higher degree of medical care. The woman indicated that, had she been properly advised, she would have ended the pregnancy.

The second claim: The woman brought a claim for damages flowing from the sterilisation performed during the birth of the baby, without her informed consent. It was alleged that the woman signed the form for consent to sterilisation before the Caesarean, but only because they had indicated that the baby would be normal.

In respect of the first claim:
The doctor on duty at the Addington hospital had a duty to inform the woman of the dangers, and to explain to her what exactly the consequences were of the fact that the first ultrasound scan was not
conclusive. He should have explained to her that an urgent re-scanning was absolutely imperative in this case. A reasonable person in the position of the doctor would have foreseen the reasonable possibility that the patient might not be followed up and might not return to the hospital, and secondly, that she possibly would not get the right advice at the clinic, which proved to be the case. In view of the fact that a breach in communication or a grave misunderstanding on clinic-level was foreseeable, it was imperative that the doctor should have at least issued a written order to the clinic, setting out clearly that the woman had to return for a re-scan. The court found that the doctor at Addington was indeed negligent and that this negligence can be causally connected to the birth of the child, who, in the absence of such negligence, would not have been born. It was found that, for the purposes of the delictual claim, there was no contributing negligence by the mother. No contributing negligence may in any case be taken into account in respect of the contractual claim. In respect of this claim the Premier incurred liability for all damages flowing from the birth of the child which the plaintiffs could prove.

In respect of the second claim:
The court was not convinced on the evidence that the hospital staff, either intentionally or negligently, acted unlawfully towards the woman, and the claim was thus rejected.

11.4.4 Premier, Kwazulu-Natal v Sonny 2011 (3) SA 424 (SCA)
The Supreme Court of Appeal did not refer in their judgment to the concept of wrongful birth, or any of the authority in that respect, but decided the case merely on the grounds of delictual liability.

The appellant alleged that the mother of the child, Jayanthi, did not see the doctor on the day of the ultrasound scan, but just left. Despite the fact that she knew she had to go for a second scan, she did not do so, and therefore has to bear the responsibility for the consequences of her actions. The court a quo found that the fact that the mother, Jayanthi, returned to the clinic on the same day that she had the scan, was to her benefit. The court a quo also deemed it important that the appellant admitted repeatedly that appointments for patients are normally made by the clinic.

In order to determine whether the appellant’s employees (hospital staff) had been negligent by sending the mother, Jayanthi, back to the clinic uninformed, the question, according to the court a quo, was whether they created the risk that she would not return for the test to determine whether the foetus is normal. The court pointed out that the court a quo used the test for negligence, as applied in Kruger v Coetzee 1966 (2) SA 428 (A) 430E, which stipulates that negligence occurs if:

(a) a diligens paterfamilias in the position of the defendant –
   (i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and
   (ii) would take reasonable steps to guard against such occurrence; and

(b) the defendant failed to take such steps.

The court referred to the view of the court a quo that the doctor should have given the mother a written instruction, and that the doctor has an obligation to give clear and unambiguous instructions to a patient. Failure to do this can cause the doctor to incur liability for negligence.

The Supreme Court of Appeal referred to the dispute in the facts, namely whether the Addington
Hospital referred the mother, Jayanthi, back to the clinic to make an appointment for the second ultrasound scan. The court referred to the appellant’s admission mentioned above, namely that the clinic always makes appointments for patients. The court pointed out that the appellant’s legal team never tried to retract this admission, and could therefore not criticise the court a quo now for relying on these admissions in its finding.

The court said that thousands of people, often poor and illiterate, use the public health facilities. They are entitled to the same treatment as patients who have private medical assistance. This means that they should be fully informed of and involved in their treatment. The court pointed out that this case is not concerned with the availability of public funds or material goods, but with the question whether a doctor communicated to the fullest extent with a patient. The court found that what is needed is a public health system that respects the dignity and rights of those who have to use the system. That is the basic sensitivity that the Constitution requires.

The court further pointed out that no fault could be found with the argument or findings of the court a quo on the facts. Furthermore, no contributory negligence could be attributed to the mother, Jayanthi. As could be expected, she followed the instructions, including the order to return to the clinic. The first ultrasound scan report was not addressed to her, but was a “recommendation” from the person who did the sonar to her doctor. A recommendation is tentative by nature. In other words, it was a suggestion made with the intention that the doctor should consider it. In the present case the doctor did not explain to Jayanthi why she accepted the recommendation, and also not why the second scan was necessary. The doctor should have done so, and she should have explained to Jayanthi why the second scan was so important. Failure to do so, together with the assurance by the clinic that the scan report contained nothing that could arouse suspicion, and the nurse’s statement that a second scan is only needed closer to the end of a pregnancy, caused Jayanthi to wrongly assume that everything was in order. The court said that such assumption by her is understandable in the circumstances, and concluded that there is no reason to interfere with the finding of the court a quo. The appeal was dismissed.

11.4.5 Conduct which may lead to a claim for wrongful birth

The following are examples of types of conduct which may lead to liability on the grounds of wrongful birth:

- failure to fulfil an agreement to end a pregnancy
- failure to successfully perform an agreement to end a pregnancy so that the foetus is indeed aborted
- failure to diagnose a serious defect or disability in a foetus prenatally
- failure to inform the parents of an unborn foetus duly about a defect or disability that has previously been diagnosed in the foetus
- misrepresentation that a foetus is normal and healthy
- misrepresentation that an abnormal foetus has been aborted

11.5 Wrongful life

11.5.1 Introduction

The majority of Western jurisdictions have so far refused claims for “wrongful life” in the narrow
sense, namely where a claim for damages is brought on behalf of the impaired infant rather than the parents. As we shall see below, the claim was also refused by the Witwatersrand court in the Friedman case. In the latter type of claim the child does not allege that the doctor caused the impairment, but that he (the doctor) was responsible for the child’s very existence. It is thus the life as such that constitutes the alleged harm.

11.5.2 Friedman v Glicksman 1996 (1) SA 1134 (W)

We have already discussed Friedman in 11.4.2 above in the context of wrongful birth. The facts of the case are set out there. As we pointed out, Alexandra’s mother also brought a claim on the grounds of wrongful life, and we will discuss this claim here. Alexandra’s mother namely brought a claim in her representative capacity on behalf of Alexandra for general damages as well as a claim for future loss of earnings.

Goldblatt J rejected the claim on the grounds of wrongful life, and gave three reasons for this decision:

(1) It would be contrary to public policy for courts to have to hold that it would be better for a party not to have the unquantifiable blessing of life rather than to have such life albeit in a marred way.

(2) To allow such a cause of action would open the door to a disabled child being entitled to sue its parents because they may have for a variety of reasons allowed such child to be born knowing of the risks inherent in such decision. Merely to state this proposition is to indicate the unacceptable burden that would be placed on such unfortunate parents.

(3) To grant damages in such cases would be completely contrary to the measure of damage allowed for in the law of delict. The defendant was in no way responsible for the child’s disabilities and yet he is being asked to compensate the child for such disabilities. This proposition is illogical and contrary to our legal system. The only measure of damages can be the difference in value between non-existence and existence in a disabled state. No criteria, in law, can exist in establishing such difference or even in establishing whether any damage has been sustained.

11.5.3 Stewart v Botha

In Stewart v Botha 2008 (6) SA 310 (SCA) the Supreme Court of Appeal rejected the appeal and confirmed the finding in Stewart v Botha 2007 (6) SA 247 (C).

This case will fall under claims brought on the grounds of wrongful life. In this case a child, Brian, was born with serious defects, inter alia a lumbo-sacral myelomeningocele, which is a type of spina bifida, and a serious defect in the development of the brain stem, as well as excessive cerebrospinal fluid on the brain (so-called “water on the brain”). In addition the nerves in his intestines, bladder and lower limbs were also affected.

The appellant’s wife (the first plaintiff in the court a quo) brought a claim in the Cape High Court against the respondents (the general practitioner and gynaecologist) whom she consulted during her pregnancy. The claim was for damages in respect of the specific harm suffered, for special education, and past and future medical expenses following from the disability. The appellant (second plaintiff) alternatively brought a delictual claim on behalf of his child for compensation for
the same harm. He alleged that the doctors had been negligent in failing to diagnose the defects in the foetus and duly inform his wife thereof. Had his wife been informed of the abnormalities, she would have ended the pregnancy, so that his son would not have been born and would not have had the serious physical defects which he indeed now had.

The respondents noted an exception against the appellants’ claim on the grounds that it did not reveal a cause of action. It was alleged that the doctors had no obligation to ensure that Brian was not born, and that a claim which recognised such legal duty would be contra bonos mores. In addition it was alleged that such a claim would also be against the public policy, in other words, they alleged that they did not act unlawfully. The High Court confirmed the respondents’ exception, and rejected the appellants’ claim.

On appeal to the Supreme Court of Appeal the court recognised the parents’ claim for harm flowing from the child’s disability, but made a distinction between the parents’ claim and that of the child in respect of the same harm.

The court pointed out that an act that causes harm to another may lead to a claim for damages, but only if, in addition to negligence, it can also by proven that the act was unlawful, in other words, if considerations of public policy require that the plaintiff in the specific circumstances be compensated for his or her harm.

The court further found that where the act that caused the harm amounts to an omission rather than a positive action, it was unlawful only to that degree that there was a legal duty on the defendant not to act negligently in the circumstances. The question whether there was such legal duty has to be determined through consideration of aspects such as public and legal policy in accordance with constitutional norms.

The court also pointed out that there had indeed been other cases where a claim for damages had been instituted in similar circumstances (here the court refers to wrongful birth), but that the question there had been one of concerned parents who wanted to claim the additional financial burden which the disabled child brought as result of negligence. In those cases there was no question of the dilemma which the present case involved, because the question there was never whether the child would have been better off had he never been born. The point of departure in those cases was acceptance that the child has indeed been born, and the purpose of the claim was to address the consequences of that birth. The crux of the present case was the existential question: Would it have been better – from the perspective of the child – not to have been born? Had the child’s claim in this case been successful, it would mean that the court would have to find that it would have been better for the child not to have been born at all. This finding implies that life as a disabled person is in itself regarded as damage. To choose no life above life as a disabled person violates the sanctity of human life (see 1.4 above).

The court pointed out that the question whether a specific child should at all have been born “goes so deeply to the heart of what it is to be human that it should not even be asked of the law” (at [28]). Therefore the court ought not to acknowledge a claim in such an instance. The court found that the Cape High Court was indeed right in rejecting the claim on the grounds of exception. The appeal was thus rejected.

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11.5.4 Effect of these types of claims

Acknowledging actions on the grounds of wrongful conception/birth has serious implications, in particular for specialists in the field of gynaecology and obstetrics.

The MPS (see 4.1.1.10) announced that the membership fees for an obstetrician increased between 2006 and 1 April 2011 from R76 130 to R187 830.

This enormous increase may cause general practitioners who render obstetric services in rural areas of South Africa to withdraw these services because the level of income generated from practice would be insufficient to meet the expected cost of protection against malpractice claims. This may also lead to a concomitant increase in obstetric services for patients, where doctors include these costs in the cost of their services.

The fact that the escalation of costs of claims against medical practitioners in the private sector is becoming a big problem for members also concerned the MPS greatly. If this tendency persists, the increasing costs and in particular the amount of damages paid for catastrophic-injury claims, will threaten the viability of private practice in those specialities where medical malpractice may lead to serious harm. Top of this list is obstetrics.

The tendency of escalating claim costs also shows in the public sector. Most claims by far are instituted against government authorities.

ACTIVITIES

1. Define wrongful pregnancy/conception, wrongful birth, and wrongful life.
2. Describe the typical factual situations where (i) wrongful pregnancy/conception, (ii) wrongful birth, and (iii) wrongful life will occur.
3. Indicate whether the following cases were based on contract or delict, or both in the alternative: (i) Behrmann v Klugman 1988 (W), (ii) Administrator of Natal v Edouard 1990 (3) SA 581 (A), (iii) Mukheiber v Raath 1999 (3) SA 1065 (SCA), (iv) Friedman v Glicksman 1996 (1) SA 1134 (W); (v) Sonny v Premier, Kwazulu-Natal 2010 (1) SA 427 (KZN), and (vi) Stewart v Botha 2008 (6) SA 310 (SCA).
4. Answer the following questions in respect of a claim on the grounds of wrongful pregnancy (number of marks indicated in brackets):
   (i) What is the name of the most important decision of the Supreme Court of Appeal concerning an action on the grounds of wrongful pregnancy? (1)
   (ii) There has been a case in South African law where a claim for wrongful pregnancy has succeeded on the grounds of misrepresentation by the doctor. Briefly state the facts of this case. (4)
   (iii) Can compensation for non-patrimonial loss in the form of the woman’s pain, suffering and discomfort be successfully claimed with the action for wrongful pregnancy? Briefly substantiate. (3)
   (iv) Is it at all relevant whether the parents initially requested sterilisation on socio-economic grounds (ie, because they could not financially support another child)? Briefly substantiate with reference to authority. (3)
5. Distinguish between wrongful birth and wrongful life, and discuss, with reference to
authority, which (if any) of these causes of action is recognised in South African law.

6. The action for wrongful pregnancy/conception was recognised by the Appellate
Division in Administrator of Natal v Edouard 1990 (3) SA 581 (A), and the action for
wrongful birth was first recognised in our law in Friedman v Glicksman 1996 (1) SA
1134 (W). Our courts are unwilling to recognise the action for wrongful life. Is it not
inconsistent to recognise the first two causes of action, but to reject the last?

According to the Supreme Court of Appeal, the reason for rejecting the action for
wrongful life despite the recognition accorded to the other two causes of action is that

(1) it would be unfair to hold the doctor liable against both the parents and the
child for the same damages.

(2) recognition of the action for wrongful life would pave the way for a disabled
child to sue his or her parents for not having him or her aborted as foetus.

(3) the action for wrongful life is the only one of these causes of action that can only
succeed if the court finds that the child would have been better off never to have
been born.

(4) recognition of wrongful life would lead to a further escalation in the cost of
obstetric services.

FEEDBACK

1. See 11.2 above. Note carefully the following: whether the particular cause of action
(i) concerns a healthy or disabled child, (ii) is instituted by the parent/s or on behalf
of the child.

2. (i) See 11.3.6 above, and also read the findings for more detailed examples.
   (ii) See 11.4.5 above, and also read the findings for more detailed examples.
   (iii) The circumstances are the same as for wrongful birth, but the claim is instituted
       by or on behalf of the child.

3. (i) Contract; alternatively delict, (ii) contract, (iii) delict (there was no agreement
to do a sterilisation the doctor made a misrepresentation that a sterilisation
was indeed done, (iv) contract, alternatively delict, (v) contract, alternatively
delict, (vi) delict.

4. (i) Administrator of Natal v Edouard (remember that you need not give the full
reference to a case in the examination, only the name).
   (ii) It is of course the facts of Raath v Mukheiber which you have to give. It is
important to do so in such detail that it is clear that there was no agreement to
do a sterilisation (and that the claim may therefore not be based on breach of
contract), but that the defendant made a misrepresentation to the plaintiff that
he indeed sterilised her. If the facts are set out fully enough, it would be clear
from the facts themselves that there was no bodily injury, but that it was a case
of mere financial loss because of a misrepresentation. When giving the facts of
a case it is important to remember that all the facts without which the reader
would not understand the finding of the court, have to be given.
   (iii) According to the finding in Administrator of Natal v Edouard non-patrimonial loss
may not be claimed on the grounds of a contract. Because of the ease with
which a delictual claim may be conjoined with a contractual claim, the judge saw
no reason to extend contractual liability to this type of loss. In the present case no delictual claim was brought together with the ex contractu claim. (In *Mukheiber v Raath*, which was indeed based on delict, no claim was brought for non-patrimonial loss.)

(iv) In *Administrator of Natal v Edouard* the court found that the father’s pregnancy claim was rightly granted by the court a quo. However, the court attached an important qualification to its finding, namely that this conclusion “is intended to pertain only to a case where, as here, a sterilisation was performed for socio-economic reasons”. There is therefore no authority for the assumption that a contractual claim for wrongful conception will succeed where sterilisation was not requested because the parents could not financially support another child. In *Mukheiber v Raath* the court said that the claim for compensation in a delictual claim is not restricted only to cases where the request for sterilisation is made for socio-economic reasons.

5. Here you have to give a definition of each cause of action to stress the differences. It is important to note that both concern the birth of a disabled child, but that a claim for wrongful birth is brought by the parent(s) while one for wrongful life is brought by or on behalf of the child. Also include a brief discussion of *Friedman v Glicksman* (covering both types of claim). It may be pointed out that the Supreme Court of Appeal in *Sonny* indeed recognised a claim which will fall under our definition of wrongful birth, without referring to it as such. Briefly also discuss *Stewart v Botha* so that it will be clear that the Supreme Court of Appeal rejected wrongful life.

6. The correct answer is (3).

(1) No such finding was made by the court.
(2) This was one of the reasons for rejecting the action for wrongful life advanced by the court in *Friedman v Glicksman*, but the Supreme Court of Appeal declined to take an unambiguous stance on the issue.
(3) The Supreme Court of Appeal pointed out that the question whether a specific child should at all have been born “goes so deeply to the heart of what it is to be human that it should not even be asked of the law”. The court also pointed out that in the other two causes of action the point is that the parents were saddled with a duty to support a child that they would not have had if it had not been for the defendant’s negligence. Carefully note the distinction, and make sure that you understand it.
(4) The court did not entertain such a possibility when it considered the question whether the action should be recognised.

**GLOSSARY**

amniocentesis Aspiration of a sample of amniotic fluid (fluid surrounding the foetus in the womb or uterus) with a hollow needle inserted through the stomach wall under ultrasound guidance into the amniotic sack. The amniotic fluid contains foetal cells on which biochemical tests are done to diagnose chromosomal and metabolic defects and abnormalities such as spina bifida.
chorionic villi sampling

Obtaining a sample of the chorionic villi (foetal cells occurring in the chorion or membrane surrounding the foetus). May be done vaginally by placing small tube through cervical opening under ultrasound guidance and aspirating cells, or trans-abdominally through stomach and uterine wall. Cells undergo chromosomal analysis and biochemical tests to diagnose abnormalities. Procedure is usually performed between 8th and 12th week of pregnancy.

contraceptives

cordocentesis

Any substance used to prevent unwanted conception or pregnancy.

Procedure for obtaining a foetal blood sample by inserting a hollow needle with ultrasound guidance through the abdominal wall of a pregnant woman into the umbilical vein (an embryonic blood vessel in umbilical cord carrying blood from placenta through umbilical cord back to the heart). Chromosome analysis and biochemical and other tests are done on the blood to test for abnormalities.

Down syndrome

Chromosomal abnormality with three of the 21st chromosomes instead of the normal two – thence the other name for this defect: trisomy-21. It is the most common cause of mental disability and physical malformation. Subnormal mental ability; eyes somewhat slanting; small round head; flat nose bridge; striated tongue; palms of hands abnormal; small, round stunted ears; short stature. Heart defects often occur. Prenatal screening can be done to gauge the chances of a woman having a Down's baby. By 14–17 weeks a sample of a substance called alphafetoprotein (AFP) may be taken. AFP normally circulates in the bloodstream of pregnant women. If foetus has certain abnormalities the AFP level is unnaturally high, or, as in the case of Down syndrome, abnormally low. The chances of having a Down syndrome baby may be calculated on the basis of the AFP level, measuring two other hormones, and the age of the pregnant woman. These results are only predictive in nature, and are correct in approximately 60% of cases. The only way to predict Down syndrome in a foetus with any degree of certainty (98–99%) is to analyse tissue through amniocentesis and chorionic villi sampling.

ex contractu


Fallopian tube ligation

Form of permanent contraception where Fallopian tubes are surgically cut or blocked to prevent pregnancy. The Fallopian tubes are the two tubes carrying egg cells (ova) from the ovaries to the uterus. Conception usually occurs in the Fallopian tubes close to the ovaries. During a ligation a small cut is made in the abdomen, the Fallopian tubes ligated or cut through in two places and the part in between cauterised, destroyed or dissected. The procedure may also be done vaginally.
<table>
<thead>
<tr>
<th>term</th>
<th>definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>general damages</td>
<td>When dealing with a delict, general damages often means damages flowing from a wrongful action. It is sometimes also a synonym for non-patrimonial loss. With delictual liability for physical injuries, all non-patrimonial loss, such as pain and suffering, as well as future loss are regarded as general damages. With breach of contract, general damages are those losses flowing naturally from the breach of contract, and in respect of which it is legally assumed that the parties did foresee it.</td>
</tr>
<tr>
<td>genetic counsellors</td>
<td>Experts counselling people who suspect that they may have a certain gene that may cause illnesses or abnormalities; also people who worry that their offspring may inherit such genes. Clients are typically people with a family history of hereditary disease.</td>
</tr>
<tr>
<td>intangible loss</td>
<td>Synonym for non-patrimonial loss.</td>
</tr>
<tr>
<td>myelomeningocele</td>
<td>A developmental defect of the central nervous system in which a hernial sac containing a part of the contents of the spinal cord, its membranes, and cerebrospinal fluid protrudes through a congenital defect or cleft in the vertebral arch. It is most often caused when the neural tube fails to close during embryonic development.</td>
</tr>
<tr>
<td>non-patrimonial loss</td>
<td>Harmful change in or factual disturbance of a person’s personality interests protected by law, which change does not affect the person’s economic situation.</td>
</tr>
<tr>
<td>Pandora’s box</td>
<td>In Greek mythology a box from which all types of disaster and illness were let loose on people after Pandora opened it out of curiosity. Only Hope was left after Pandora slammed shut the lid. Figuratively it is something causing many unforeseen problems, and is a source of endless misfortune.</td>
</tr>
<tr>
<td>patrimonial loss</td>
<td>Calculable monetary loss or decrease in the plaintiff’s patrimony (estate) – the loss or reduction in value of a positive asset in the plaintiff’s estate, or the creation or increase of a negative element of his/her estate.</td>
</tr>
<tr>
<td>pedantic</td>
<td>Describes an attitude of excessive concern with book-learning, rules and minor detail; presumptuousness. Said of someone who is concerned with parading technical knowledge.</td>
</tr>
<tr>
<td>psychopath</td>
<td>Someone acting in a grossly anti-social manner, feels little or no guilt about such behaviour, and has limited capacity for establishing normal social relationships.</td>
</tr>
<tr>
<td>pure economic loss</td>
<td>Patrimonial loss which does not result from damage to property or infringement of interests of personality.</td>
</tr>
</tbody>
</table>
| recanalisation of the vas deferens          | Spontaneous recanalisation occurs when vas deferens automatically "grows back", causing the man to be fertile again. It is unlikely that the man will be fully fertile, as any re-growth will probably result in a much narrower channel than before. Early and late recanalisation occurs. The first occurs when recanalisation happens in the early weeks after a
**vasectomy**, before patient's infertility has been confirmed through semen analysis. Later recanalisation occurs after infertility has been established. Recanalisation occurs when the cut ends of the **vas deferens** spontaneously joins together. This may be through granulation, which is a normal stage of wound healing where little round outgrowths consisting of connective tissue and white blood cells (and with a **vasectomy** also sperm) form on the surface of the wound where healing is occurring. Cells from the lining of the **vas deferens** can grow through the connective tissue and form a new channel for the sperm. The forming of a new channel may normally be minimised by leaving a gap between the two cut ends.

**sanctity of human life**
Concept often used in medical ethics and medical law. Although it is rooted in Judeo-Christian ethics, it is widely accepted in secular ethics. Embody idea that human life has intrinsic value. A human thus deserves respect merely by being human.

**sperm count**
Estimate of the concentration sperm in ejaculated semen to measure male fertility. Normal sperm count is between 300 and 500 million in the total ejaculate. Less than 60 million normally indicates sterility.

**spina bifida**
A serious birth defect in which the spinal cord is malformed and lacks the coverings that normally protect the skeletal and soft tissue. This leaves an opening in the spinal canal. Part of the contents of the spinal cord and the membranes may protrude, often resulting in neurological disorder.

**ultrasound scan**
Sonar examination.

**vas deferens**
One of a number of tubes carrying sperm during ejaculation from the epididymus to the urethra. The epididymus is a convoluted tube between the testes and the **vas deferens** in which sperm move during maturation, and are stored until ejaculated. The urethra is the tube carrying urine from the bladder to the outside and also serves as ejaculatory tube.

**vasectomy**
Surgical procedure where the **vas deferens** is severed. A vasectomy of both **vasa deferentia** causes sterility and is a popular contraceptive method.

**wrongful birth**
Cases where parent(s) of a disabled or handicapped child themselves bring a claim against the party allegedly responsible for failing to prevent the child's birth.

**wrongful life**
Cases where disabled or handicapped child or the parent(s) of such child on behalf of the child bring a claim against the party allegedly responsible for failing to prevent the child's birth (life).

**wrongful pregnancy**
Cases where parent(s) of healthy but unwanted child claim against the party allegedly responsible for failing to prevent conception or pregnancy. Also called wrongful conception.