MEDICAL LAW NOTES

Medical law focuses on the negligence of medical staff in society. We will look at what rights one has as an individual with regards to health etc. How doctors can practice and protect themselves and numerous other aspects.

You need to bear in mind that many things in medical law may overlap and therefore in answering any long question ensure that you include as much information as possible.

There are various different legislations to learn in medical so ensure that you do not confuse a section number with the incorrect Act.

Dr Henry Lerm, in a Medical Seminar hosted by the Law Society of South Africa – legal education and development (LEAD) held in Pretoria on 7 April 2011 stated:

> *"Medicine is almost as old as civilization. Despite many centuries of its existence, this field remains complex and very much inexact. But should the earth swallow the mistakes made by those who we rely on to exercise care and diligence without them accounting for their conduct? You be the judge."*

That's a question that ought to ponder in your mind throughout this course – should a doctor be held liable in each and every circumstance? And if so, then on what basis?

In this course, you will learn that medical claims can originate from one of the following sources:

- *Contract*
- *Delict*
- *Criminal*

Please ensure that in answering a question you refer to the correct source.

Your work is based on the following source:

Coetzee LC, Pienaar L, *Medical Law*, University of South Africa, Pretoria, 2012

THE SOUTH AFRICAN HEALTH CARE SYSTEM

In South Africa we distinguish between practitioners who are employed by the State and those who practice for their own account.

Private practitioners are not employed by the state but have their own private practice. When entering into a relationship, it is done directly (contractual).
In terms of an agreement between the doctor and patient it is not a "free-enterprise". This is because the law has placed limitations upon the terms of a contract (A doctor is not at liability to charge a patient as he wishes). If an unreasonable fee is charged and the patient has applied to the HPCSA for determination, the fee will not be recoverable in so far as it is unreasonable.

In South Africa there is no national health service but a provision has been made for provincial hospitals and clinics to offer medical services at a reduced rate or fee. Although we have this available, **an individual has no absolute right to health care.**

A substantial number of health-care professionals are employed by the Department of Health, government and municipalities.
State hospitals also admit private patients as these hospitals offer special facilities which are not provide by all private institutions. E.g. ICU.

In a state hospital admission is at the discretion of the super intendent whereas a private hospital has an absolute discretion. This discretion is, however, subject to S27 (emergency).

Who is entitled to free or reduced public health care?

The National Health Act (Section 4(1)): empowers the Minister of Health to prescribe conditions, regarding which people are eligible for free health care services at a public health establishment.

S4 (3): of the NHA: state clinics and health centers provided by the state must provide:

- Pregnant and lactating woman and children under 6 who aren't members of a medical aid with free health care
- All people (except members of medical aid schemes) and their dependents and all people getting compensation for an occupational disease with free primary health care services
- Woman, subject to the Choice of Termination of Pregnancy Act, with free terminations of pregnancy.

Section 59 of the Health Professions Act states that specialists may not preform acts which do not belong to their speciality except in accordance with section 27 of the Constitution.
No remuneration is recoverable for such acts and a person contravening this section could be faced with a punishment of 12 months imprisonment.

The National Department of Health has hoped to make membership of medical schemes more affordable. In attempting to do this they planned to introduce a National Health Insurance in 2012 but it has been seen that this will be expensive to implement. In order to implement such a system we would need to:

- Improve hospitals drastically
- Develop our infrastructure
- Improve our human resource system
- And make changes to our administration and management of our healthcare

The National Health Insurance is aimed at ensuring that all South Africans have access to health care and is hoping to take into account and deal with the diseases that are most common and crippling South Africa. These include:

- HIV / AIDS
- Tuberculosis
- Mother, infant and child death
- Non-communicable diseases like cancer, mental illness, chronic heart and lung disease, high blood pressure and diabetes

The National Health Insurance will not cover, *inter alia,* cosmetic plastic surgery, botox or expensive spectacles.

This system will be funded from the taxes paid by the higher income earners in society and administered by the public sector.

The policy has been set in the Government Gazette for comment and projects were said to be launched in 10 districts in 2012 with the entire system now taking about 14 years to introduce.

HOW CAN DOCTORS PRACTICE AND WORK TOGETHER WITH OTHER DOCTORS AND DEAL WITH THEIR PATIENTS

THE CONTRACT BETWEEN DOCTOR AND PATIENT

Mutual rights and duties

A patient in consulting a doctor enters into a contractual relationship with him.
A doctor in private practice is a free agent or independent consultant and can accept or refuse patients as he chooses. The exception to this is S27, dire emergency. A doctor who is available may not ethically nor legally refuse to attend to a patient, unless there are compelling circumstances which prevent the doctor from acting, e.g. drunk.

Doctors and nurses working in public hospitals may not refuse to attend to a particular type of patient. The SA Nursing Association in 1998 ruled that it would be unethical for a nurse to refuse to attend to a patient with AIDS.

A medical practitioner can refuse to treat anyone who is physically or verbally abusive subject to section 27.

By common law, there is a duty on the employer to provide safe working conditions, e.g. furnishing employees with equipment required to avoid unnecessary health risks and to inform employees on all precautions to be taken.

The contract entered into is in a tacit agreement where the doctor undertakes to diagnose and treat the patient in a normal way. Any unusual procedures must firstly be discussed with the patient. The undertaking of this agreement does not mean that the doctor will treat the patient personally. He can refer the patient to a specialist.
By undertaking a case, a doctor does not guarantee that the patient will be cured.

In Chalk v Fassler, the judge remarked that no comparison can be drawn between an agreement to repair a car and that to treat a patient medically. With reasonable care and skill a car can be repaired. However, surgery holds a risk.

Should a doctor be so unwise as to expressly guarantee a cure, a patient might be able to claim damages for breach of contract in the doctor's failing to fulfill his undertaking. Ordinarily, the doctor undertakes to treat the patient with reasonable care, competence and skill – the reasonable doctor.

If the doctor departs from the patients express instructions or fails to treat him in a manner tacitly agreed upon, he can be guilty of breach and be denied the right to claim remuneration for services. E.g. a dentist furnishing ill-fitting dentures, a doctor undertaking to do an operation and handing the patient over to another doctor.

In Administration of Natal v Edouard a hospital authority was held liable for damages arising from breach where a sterilization on a woman was meant to be done, but subsequently she fell pregnant.

The patient's claim does not necessarily have to depend on proof of the existence of the contract, the patient can also rely on delict.

Once a treatment has commenced a doctor may not simply abandon the patient.
The patient must perform his part of the agreement by making himself available for treatment. Should he fail to do so, a doctor cannot force him to submit to treatment but can hold him liable for the financial loss caused by such failure (fee).

Specific provisions relating to the cancellation of appointments were contained in rules accompanying the tariff of fees. It is provided that unless timely steps are taken to cancel an appointment for consultation, the relevant consultation fee may be charged. For a general practitioner "timely" means two hours and for a specialist, 24 hours.

Section 46 of the NHA states that 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 the staff.

Most medical practitioners belong to the Medical Protection Society (MPS) which offers discretionary indemnity cover to its members even for damages that arise from an action which constitutes a criminal offence.

Medical fees

Medical fees must be reasonable.

The Health Professions Act provides that unless the circumstances make it impossible, a medical practitioner, before rendering his services, must inform the patient or any responsible person of the fee. This must only be done where the doctor is requested or where fees exceed that usually charged.

The doctor must furnish the patient with a detailed account within a reasonable period to even where an account was rendered to a medical scheme.

A patient may within 3 months of receiving the account apply in writing to a professional board to determine if the fee charged is reasonable.

The answer to the question of what is a reasonable fee is that there is no general fee but one must be guided by a price list compelled by the council for medical schemes.

Where an account has been rendered, a medical scheme must pay within 30days. A medical scheme may not refuse to pay a benefit as a result of late submission of the account before the end of the fourth month from the last date of service rendered. Where a practitioner has rendered an account to a medical scheme they must render one to the patient.

All schemes are compelled to make provisions for certain minimum benefits, which would be the current fees charged by public hospitals. But medical schemes may offer enhanced benefits in special options for its members.

Before 2003, three different bodies compiled the tariff structure.

1. Board of Health Care Funders (BHF)
2. SAMA
3. Hospital Association of South Africa (HASA)

In 2003 the competition commission found these tariff structures conclusive and amounted to illegal price-binding. Medical schemes now tend to enter into direct negotiations with providers in order to determine the fee that will be paid directly to the provider.

Regardless of the scale, it is the patient who in final analysis remains liable for settlement of the account.

MUTUAL CONTRACTUAL RELATIONS BETWEEN DOCTORS – HOW DOCTORS PRACTICE TOGETHER

"Partnership"

Partners share profits and losses. An advantage is that if a partner falls ill he does not lose his income because he continues to share in the income generated by the other partners. The disadvantages are that relations may become strained if one of the partners does not pull his weight and the insolvency of one of the partners may also create problems.
In the past a partnership was limited to 20 people but in terms of the new Companies Act, there is no longer a limit on the number of membership.
For these reasons, the customs arose for doctors to practice in the form of a kind of free "association".

"Associate practice"

An agreement by which facilities are shared (an alternative). This means that doctors are not sharing in both profit and loss but each practices for his own profit, yet they share certain facilities, e.g. rooms, equipment etc.

Doctors in "association" are mutually available for each others patients. The important characteristic is that profits are not pooled and therefore no separate estate arises. These doctors also make the occasional use of the formation of a company to possess and control independent assets. Therefore, fixed property on which consulting rooms are situated can be owned by a company in which doctors are individual shareholders.

Medical practice by means of "companies"

In terms of the Act, corporate practice, that is, a registered company, is generally prohibited for doctors. The Minister of Health may, on the recommendation of the Health Professions Council, exempt any juristic person, from any of the provisions.

The current conditions for practice in corporate form:

- The company must be incorporated and registered as a private (profit) company.
- The company's memorandum must provide that directors shall be liable, together with the company, for the debts and liabilities of the company incurred during their term of office.
- Only doctors and members of supplementary health service professions registered, can be shareholders.
- A greater measure of continuity as far as possession.
- There could also be some tax advantages.
- There is a rule that no person may have a share in the profits unless they are a shareholder.

Practice in medical and health "networks" – "collaborative practice"

In recent years several organizations, usually in the form of companies, have come into being to facilitate coordination of services in the field of primary health care. They can be described as brokers in this field. Such a company may own, lease or sublease rooms to, for e.g. a clinic. This has become as a medical and health network.

Their objective is to facilitate the access of patients to a variety of medical practitioners and related health-care providers located in one centre. The doctors are not employed by the company itself (illegal) but will lease rooms. Such a company will then enter into agreements with medical schemes in terms of which the members of the medical scheme will have access to health-care providers at the centre at a fixed reduced rate. These agreements are known as "capitation". This means that the medical scheme pays to the company a pre-negotiated fixed fee.

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

DOCTORS PROTECTING THEIR PRACTICE FROM COMPETITION BY MEANS OF A RESTRAINT OF TRADE

When a medical practitioner employs a professional assistant and insists on including a condition in the agreement, that upon termination, the assistant cannot practice for a certain period within the general area in which the medical practitioner practices.

The object of a restraint clause is self evident: a senior practitioner has established a practice with success that he needs assistance. Through being employed, the young practitioner is introduced to a large number of patients and in time also wins the confidence of patients. This exposes the senior to the danger and so in order to diminish the risk, the senior prevents the junior from practicing in the same neighbourhood. The clause serves to protect practitioners and prevent future competition including the drawing of new patients.

A restraint of trade weighs up ones freedom of trade against the principle of sanctity of a contract.

This type of clause has often been a subject of dispute. In the past, the courts approached these clauses with dislike because they could harm free trade. Such principles were in principle null and void and the onus was on the person who wanted to enforce the clause – the ex-employer.

Today a clause restricting trade is not invalid and unenforceable. A covenant which restricts someone's freedom to trade is not always against public policy. It is valid if it is reasonable.

What is reasonable is determined by asking the following:

- Does the party in whose favour the restraint operates have an interest that deserves protection?
- Is the interest affected by the party against whom the restraint lies?
- Is the restraint of one party's freedom of trade needed to protect another party's interest?
- Is there any aspect of public interest that requires the restraint not to be upheld?

The person who alleges that he is not bound by the restraint clause bears the onus of proving so.

The court is not limited to the finding that a restraint is enforceable or unenforceable in its entity, but is entitled to decide that only a part of such clause is.

The factors that the courts look at to determine the reasonableness is the area in which the restraint operates, the period and the scope of the activities. Every case is dealt with on its own merits. In considering the public interest, the court will have regard to the availability of similar, alternative services.

Before the courts looked at if the parties were on equal footing. If they were the restraint of trade was reasonable. Now with trade unions the employee may be in a stronger position.

Now, section 22 of the Constitution guarantees a person's right to choose their trade. However this clause may be limited and regulated by law.

Examples

1. *Locum tenens* restrained from practicing as a general practitioner within 5miles / 8km for 5 years. Upheld. Estate Matthews
2. Seller of general practice retrained within 10 miles / 15km from city hall, Cape Town, except as a specialist or employee of health-care authority, no period stipulated – period therefore indefinite. Upheld. Weinberg v Mervis
3. Professional assistant restrained for two years within 4 miles / 6km. Upheld. Rogaly v Weingarts
4. Ear, nose and throat specialist restrained for three years, within 60 miles / 90km. Upheld. Savage and Pugh v Knox
5. Partner leaving general practice restrained from general practice but not specialist practice for 5 years. Upheld. Hermer v Fisher and Others
6. Partner leaving general practice restrained from practicing in any capacity for 3 years within 50km. Period held unreasonably long. Scaled down to 12 months. Ntsanwisi v Mbombi

In Kleynstruber v Barr the court held that a restraint is unreasonable where the service supplied (superior physiotherapy) was of a unique nature and not available anywhere else in South Africa.

Penalty clause

This is a provision in which a party, who acts in contravention of a contractual obligation, is liable to pay a sum of money to the innocent party, whether by way of penalty or as liquidated **damages.**
The creditor is not entitled to claim damages in addition to a penalty sum. He may also not claim damages in lieu of the penalty sum, unless the particular contract expressly so provides.
Serves to protect practitioners and prevent future competition including the drawing of new patients.

Weinberg v Mervis shows an example of a penalty clause attached to a restraint of trade. Here the purchaser of a practice protected himself by way of stipulation that if the vendor contravened the restraint, he would be liable to pay a fixed sum to the purchaser in respect of each breach.

QUESTIONS

In January 2004 the Minister of Health announced her intention to introduce a system of "transparent pricing" of medicines, which in effect would amount to price control of medicines. The intent was to keep medicine prices low.
Discuss the rights and obligations of doctors in setting up joint practices in the form of:

a. **Associate practices**
b. **Registered companies**
c. **Medical and health networks**

Associate practice:

Partners share profits and losses. An advantage is that if a partner falls ill he does not lose his income because he continues to share in the income generated by the other partners. The disadvantages are that relations may become strained if one of the partners does not pull his weight and the insolvency of one of the partners may also create problems. For these reasons, the customs arose for doctors to practice in the form of a kind of free "association". An agreement by which facilities are shared (an alternative). This means that doctors are not sharing in both profit and loss but each practices for his own profit, yet they share certain facilities, e.g. rooms, equipment etc.

Doctors in "association" are mutually available for each others patients. The important characteristic is that profits are not pooled and therefore no separate estate arises. These doctors also make the occasional use of the formation of a company to possess and control independent assets. Therefore, fixed property on which consulting rooms are situated can be owned by a company in which doctors are individual shareholders.

Medical practice by means of companies: In terms of the Act, corporate practice, that is, a registered company is generally prohibited for doctors. The Minister of Health may, on the recommendation of the Health Professions Council, exempt any juristic person, from any of the provisions.

The current conditions for practice in corporate form:

- The company must be incorporated and registered as a private company.
- The company's memorandum must provide that directors shall be liable, together with the company, for the debts and liabilities of the company incurred during their term of office. – personal liability.
- Only doctors and members of supplementary health service professions registered can be shareholders.
- Joint practice results in a greater measure of continuity as far as possession.
- There could also be some tax advantages.

Practice in medical and health "networks" – "collaborative practice": In recent years several organizations, usually in the form of companies, have come into being to facilitate coordination of services in the field of primary health care. They can be described as brokers in this field. Such a company may own, lease or sublease rooms to, for e.g. a clinic. This has become as a medical and health network.
Their objective is to facilitate the access of patients to a variety of medical practitioners and related health-care providers located in one centre. The doctors are not employed by the company itself (illegal) but will lease rooms. Such a company will then enter into agreements with medical schemes in terms of which the members of the medical scheme will have access to health-care providers at the centre at a fixed educed rate. These agreements are known as "capitation". This means that the medical scheme pays to the company a pre-negotiated fixed fee.
Doctors and patients are not always happy with restrictions placed upon treatment regimes as determined by the system of managed health care, which decidedly results in lower medical costs.

A doctor, in charging fees for medical services to a patient must act in accordance with the tariff scale otherwise the patient's medical scheme won't pay the fees directly to the doctor

Medical fees must be reasonable.
The Health Professions Act provides that unless the circumstances make it impossible, a medical practitioner, before rendering his services, must inform the patient or any responsible person of the fee. This must only be done where the doctor is requested or where fees exceed that usually charged.

The doctor must furnish the patient with a detailed account within a reasonable period to even where an account was rendered to a medical scheme.
The answer to the question of what is a reasonable fee is that there is no general fee but one must be guided by a price list compelled by the council for medical schemes.

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In 2003 the competition commission found these tariff structures conclusive and amounted to illegal price-binding. Medical schemes now tend to enter

into direct negotiations with providers in order to determine the fee that will be paid directly to the provider.

Regardless of the scale, it is the patient who in final analysis remains liable for settlement of the account.

Discuss the enforceability of the restraint of trade

Here you need to discuss covenants in restraint of trade (ROT). Explain / define what a ROT is and how it is applicable: -
When a medical practitioner employs a professional assistant and insists on including a condition in the agreement, that upon termination, the assistant cannot practice for a certain period within the general area in which the medical practitioner practices.
The object of a restraint clause is self evident: a senior practitioner has established a practice with success that he needs assistance. Through being employed, the young practitioner is introduced to a large number of patients and in time also wins the confidence of patients. This exposes the senior to the danger and so in order to diminish the risk, the senior prevents the junior from practicing in the same neighbourhood. The clause serves to protect practitioners and prevent future competition including the drawing of new patients.

Then explain what is the validity and enforceability of ROT: - This type of clause has often been a subject of dispute. In the past, the courts approached these clauses with dislike because they could harm free trade. Such principles were in principle null and void and the onus was on the person who wanted to enforce the clause – the ex-employer.
A clause restricting trade is not invalid and unenforceable. A covenant which restricts someone's freedom to trade is not always against public policy.

The person who alleges that he is not bound by the restraint clause bears the onus of proving so.
The court is not limited to the finding that a restraint is enforceable or unenforceable in its entity, but is entitled to decide that only a part of such clause is.

The factors that the courts look at to determine the reasonableness is the area in which the restraint operates, the period and the scope of the activities. Every case is dealt with on its own merits. In considering the public interest, the court will have regard to the availability of similar, alternative services.

Before the courts looked at if the parties were on equal footing. If they were the restraint of trade was reasonable. Now with trade unions the employee may be in a stronger position.

The give some examples of ROT in practice:
Locum tenens restrained from practicing as a general practitioner within 5miles / 8km for 5 years. Upheld. Estate Matthews

Then briefly include a penalty clause: - This is a provision in which a party, who acts in contravention of a contractual obligation, is liable to pay a sum of money to the innocent party, whether by way of penalty or as liquidated damages. The creditor is not entitled to claim damages in addition to a penalty sum. He may also not claim damages in lieu of the penalty sum, unless the particular contract expressly so provides.

When are clinics and hospitals obliged to provide medical treatment with regards to the National Health Act?

Or

Is provision made in SA for free health services?
(Not entirely but provision is made for certain services free of charge)

S4 (3): of the NHA: state clinics and health centers provided by the state must provide:

- Pregnant and lactating woman and children under 6 who aren't members of a medical aid with free health care
- All people (except members of medical aid schemes) and their dependents and all people getting compensation for an occupational disease with free primary health care services
- Woman, subject to the Choice of Termination of Pregnancy Act, with free terminations of pregnancy.

S5: states that a person may not be refused emergency medical treatment".

REGULATION OF THE MEDICAL PROFESSION BY THE LAW

HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA (HPCSA)

HPCSA is governed by the Health Professions Act. Section 3 states what the HPCSA's objects are:

- Co-ordinate the activities of the professional boards
- Promote and regulate interprofessional liaison between registered practitioners and the public
- To determine strategic policy with regard to the professional boards and registered professions for matters including finance, education, ethics, registrations, etc.
- Consult and liaise with relevant authorities.
- Assist in the promotion of health of the population
- Control and exercise authority in respect of all matters affecting the training of persons for diagnosis, treatment or prevention.
- Advise the Minister on any matter falling within the scope of the Act
- Communicate to the Minister information of public importance
- Uphold and maintain professional and ethical standards
- To ensure the investigation of complaints and appropriate disciplinary action is taken.
- To ensure that the annual budget for the council and professional boards is drawn up.

In terms of section 15 of the Health Professions Act, the Minister must, on 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, e.g. The Medical and Dental Council, Occupational Therapy and Medical Orthotics.

COMPULSORY COMMUNITY SERVICE

This is remunerated service for one year. The Minister will determine the place or places where services will be preformed. (Public hospitals)

Magistrate may, after consultation with HPCSA, make regulations with regards to places, remuneration and conditions of employment.

CONTINUING EDUCATION MAY BE REQUIRED

The council may make rules which prescribe:

- conditions regarding continual education and training to retain registration
- nature and extent of such education and training
- criteria for recognition of continuing education

In 1999 continuing education became compulsory. A practitioner is required to earn 30 Continuing Education Units (CEU) over a period of 12 months with 5 units being in the field of ethics.

PRACTICE BY UNREGISTERED PERSONS PROHIBITED

Section 17 of the Health Professions Act.

- It is a criminal offence for an unregistered person to practice **for gain**. This excludes registered nurses and pharmacists etc.
- The Act also declares punishable a series of individual acts preformed for gain:
  - (a) physically examining someone
  - (b) perform any acts of diagnosis, treatment or prevention
  - (c) advising someone on their physical state
  - (d) on information obtained from the person, diagnosing, supplying, selling or prescribing medicine or treatment
  - (e) prescribe or supply any medicine or substance
  - (f) performing any act pertaining to a medical practitioner's profession
- It's an offence to diagnose, treat or prevent any physical defect, illness or deficiency in any person, by virtue to obtain any benefit.
- It is an offence where an unregistered person, whether for gain or not, to diagnose, treat, prescribe a cure, treatment or medicine for cancer.

A conviction can lead to a fine or 12months imprisonment (section 17 of the Health Professions Act).

It is an offence to pretend to be a medical practitioner or to use the name.

The prohibition on the use of the term Doctor does not prevent a chiropractor, homeopath, etc. from using it. The prohibition is aimed at preventing a person from using the title to mislead others

Provision is made for the suspension of registration of health professionals (section 19). The registrar may suspend a registration if he:

- failed to comply with the requirements in respect of continuing professional development
- on the basis of a complaint lodged with the council

ACTS PERTAINING TO THE DENTAL PROFESSION

Section 33 of the Health Professions Act lists the following as dental acts:

- the physical clinical examination of the oral, maxillofacial and related structures of a person,
- making a diagnosis of diseases, injuries and conditions of oral, maxillofacial and related structures, including determining the relevance of systemic conditions and / or giving advice on such conditions
- performing dental procedures and prescribing medicine aimed at managing the oral health of a patient, including prevention, treatment and rehabilitation.
- performing any procedure on a patient aimed at fitting or supplying a dental prosthesis or appliance

- performing any aesthetic or cosmetic procedure on a patient pertaining to the oral and peri-oral area.

Regulation 3 does not prohibit:

- a medical practitioner from performing any acts pertaining to dentistry in cases of emergency
- the employment by and under the supervision of any person registered under the Dental Technicians Act
- any person from making or repairing artificial dentures for his own profit. Provided that such work is carried out upon the instructions of a dentist
- any person registered under the act from performing acts of dentistry.

UNPROFESSIONAL CONDUCT

This is improper, disgraceful, dishonourable or unworthy conduct.
A professional board has the power to institute an inquiry into any complaint against a person registered. This power is delegated to a professional conduct committee.
A professional board is the only power to decide what is ethical and unethical in medical practice. This power must be exercised subject to the values protected by the Bill of Rights.

Categories for doctors and dentists in general:

- advertising, business advertisements, letterheads, fees, covering, secret remedies, sharing consulting rooms, practice names.

The court has a duty to bring proof of unprofessional conduct on a part of a practitioner which was disclosed in a course of a trial to the attention of the professional board concerned. This is dealt with under disciplinary power if the board finds such offence unprofessional.

DISCIPLINARY POWERS OF THE PROFESSIONAL BOARD

A professional board is rested with the power of instituting an inquiry into alleged unprofessional conduct in terms of section 41. Where a complaint form the subject of a criminal case, the board may postpone the holding of an inquiry until the court case has been determined.

A complaint must be in writing to a professional board, HPCSA or registrar. If it is not directly made to the registrar, it must be brought to the registrars attention, who must then peruse and analyse same and to categorise them and record each complaint against the name of the respondent.

In Pretorius v SA Geneeskundige en Tandheelkundige Raad an ophthalmologist was found guilty of improper conducted where he tested a woman's eyes and supplied glasses to her while there were optometrists in town. He also refused to give her a copy of the prescription.

The registrar must refer complaints and matters which are not within the jurisdiction of the HPCSA to the ombudsman for mediation.
The ombudsman must then:

- mediate any minor transgression in aim of resolving same
- refer matters which can't be solved to the registrar for a preliminary investigation
- refer a matter to an appropriate board or tribunal

PRELIMINARY ENQUIRY BY A PRELIMINARY COMMITTEE OF ENQUIRY

Upon receiving the complaint, the registrar must register the complaint and inform the respondent of the complaint. The registrar must request the respondent to give a written response within 40 days. This response could include a written communication of the respondent's right to remain silent. All documents, whether including a response or not, must be submitted to a preliminary committee of inquiry.

If the respondent does not respond, he will be issued with a written notice instructing him to appear before the committee. The committee has to then:

- find the respondent guilty and impose a penalty (a warning or reprimand or a prescribed fee)
- order the respondent to submit his written response
- direct the registrar to confirm its decision in writing to the respondent, including his reasons for the decision.

The preliminary committee of enquiry may allow the respondent to pay an admission of guilt fine or direct that an inquiry be held.

If the respondent fails to attend the meeting, the committee may:

- find the respondent guilty and impose a penalty for contempt
- order the respondent to submit his written response
- direct the registrar to confirm its decision in writing to the respondent, including his reasons for the decision.

A conviction and punishment imposed will take effect immediately but may be set aside on application by a high court.

If the respondent did give an explanation, the committee may make one of the following findings:

- there are no grounds for taking any further action
- the respondent acted unprofessionally but the conduct is only a minor transgression – the committee must determine a suitable penalty and direct the registrar to inform the respondent in writing of the penalty which must be accepted or rejected within 14 days.
- there are grounds for a professional enquiry into the conduct of the respondent

INQUIRIES INTO UNPROFESSIONAL CONDUCT

The registrar or the investigating officer must compile a report of the investigation (section 41A). If it is compiled by the investigating officer it must be submitted to the registrar. If the report shows *prima facie* evidence of unprofessional conduct and no complaint has been laid, such report shall serve the purpose of the complaint and the registrar must serve a copy on the person concerned. A copy is served even if no evidence is found.
A practitioner whose conduct is subject to an enquiry shall have the opportunity of answering to the charge. (Section 42)

A professional board may impose one / more penalties such as:

1. a caution or reprimand
2. suspension for a specific period from practicing or performing acts
3. removal of name from the register
4. fine not exceeding R10 000
5. compulsory period of professional service
6. payment of the costs of the proceedings or restitution

PREFORMANCE ASSESSMENT

If the committee finds that the evidence points to poor performance by the respondent, it may impose practice restrictions and refer the matter to a performance assessment committee.

At the conclusion of the assessment the performance assessment committee must make a determination on how to deal with the respondent's poor work performance and direct the respondent in a manner to improve their performance. The respondent is then required to submit reports in order to make a final determination.

If on the grounds submitted in the report, the performance committee is satisfied that the respondent has acquired the required skill it may lift any practice restrictions but if they are not satisfied the committee must determine the skills required.

APPEAL AGAINST ADVERSE DISCIPLINARY FINDINGS AND REVIEW

Appeal

There are two types of appeals:
1. Internal – the possibility of an appeal to an appeal committee who will vary, confirm or set aside the finding of disciplinary committee.
2. External – the possibility of appeal to the high court against a decision of the council itself, by any person who is aggrieved by a decision.

Must first go internal before you can go external.

In the past an "appeal" was not confined to a hearing of the merits on the evidence heard but would allow the hearing of fresh evidence.
This uncertainty was settled in Health Professions Council of South Africa v De Bruin where it was held that an appeal is an appeal in the normal sense and it is therefore a rehearing on the merits based solely on the evidence upon which the decision was made. This was confirmed in De Beer v Raad vir Gesondheidsberoepe van SA.

The courts will insist that aggrieved parties appeal firstly to the appeal committee, thereafter to the court, where appeals in disciplinary matters are concerned.

Review

An aggrieved practitioner may the proceedings of a professional board on review to the high court by virtue of common-law powers of review. Review procedures may be directed largely at the manner in which the professional board has arrived at its findings, it may also be considered on the basis of the substance and merit of a finding.

RESTRICTIONS ON IMPAIRED STUDENTS OR PRACTITIONERS

Regulations may be made by the minister relating to inquires of students or practitioners who appear to be impaired, on the assessment of their condition, their suspension or removal, revocation of conditions or acts committed before r during investigation. "Impaired" – a mental or physical condition or the abused or dependence on chemical substances.

QUESTIONS

Write notes on the following:

- **Compulsory community service**

This is remunerated service for one year. The Minister will determine the place or places where services will be preformed. (Public hospitals)

- **Continuing medical education**

The council may make rules which prescribe:
- Conditions regarding continual education and training to retain registration
- Nature and extent of such education and training
- Criteria for recognition of continuing education

In 1999 continuing education became compulsory. A practitioner is required to earn 30 CEU points in 12 months.

- **The disciplinary power of the professional board in terms of the Health Professions Act**

A professional board is rested with the power of instituting an inquiry into alleged unprofessional conduct. Where a complaint form the subject of a criminal case, the board may postpone the holding of an inquiry until the court case has been determined.

A professional board may oppose penalties such as:
1. A caution or reprimand
2. Suspension for a specific period from practicing or performing acts
3. Removal of name from the register
4. Fine not exceeding R10 000
5. Compulsory period of professional service
6. Payment of the costs of the proceedings or restitution

If the question requires more information you can include unprofessional conduct.

In addition to the general provision against an unregistered person practicing as a medical practitioner, the Health Professions Act 56 of 1974 (s 36(1) (b)) also declares punishable a series of individual acts performed for gain. List these acts, and then discuss *S v Aandeweg 1986 (1) SA 211 (C)* in this context.

- It is a criminal offence for an unregistered person to practice **for gain**. This excludes registered nurses and pharmacists etc.
- The Act also declares punishable a series of individual acts preformed for gain:

(a) physically examining someone
(b) perform any acts of diagnosis, treatment or prevention
(c) advising someone on their physical state
(d) on information obtained from the person, diagnosing, supplying, selling or prescribing medicine or treatment
(e) prescribe or supply any medicine or substance
(f) performing any act pertaining to a medical practitioner's profession

- It's an offence to diagnose, treat or prevent any physical defect, illness or deficiency in any person, by virtue to obtain any benefit.
- It is an offence to pretend to be a medical practitioner or to use the name.
- It is an offence where an unregistered person, whether for gain or not, to diagnose, treat, prescribe a cure, treatment or medicine for cancer.

A conviction can lead to a fine or 12months imprisonment.
The prohibition on the use of the term Doctor does not prevent a chiropractor, homeopath, etc. from using it. The prohibition is aimed at preventing a person from using the title to mislead others.

It is an offence for any unregistered person to diagnose, treat or prevent any physical defect, illness or deficiency in any patient, and, by virtue of such act, to obtain either for himself, or for another person, any benefit.

VARIOUS PROVISIONS RELATING TO MEDICINES PRESCRIBED FOR OR SUPPLIED TO PATIENTS

DISPENSING OF MEDICINES

Doctors, dentists etc. have a limited right to compound or dispense medicine. In terms of S52 of the Health Professions Act, they may only do so on the authority and subject to conditions of a Director-General of Health.

A licensed practitioner may not keep an open shop or pharmacy – section 22. "Open shop" – where the supply of medicines to the public is not done by prescription.

Requirements and limitations to register an open shop include:
- practitioner must have completed a supplementary course by SA Pharmacy Council.
- a license may be issued "on the prescribed conditions"
- an application fee is payable
- the license is valid for a prescribed period and must be renewed by way of application. A fee is also payable
- the Director-General can revoke or suspend a license on grounds such as failure to comply with the conditions imposed

The issuing is governed by Government Notice. A formal application must be made, where the applicant must advertise his intention to apply for such license in a newspaper circulating the relevant area.
In considering the application, regard must be given to:
- the existence of other licensed facilities in the vicinity
- representations made by other interested parties
- the geographic area to be served by the applicant
- demographic considerations, including disease patterns and health status of users to be served

A license will be valid for three years. Thereafter it needs to be renewed periodically.

GENERIC SUBSTITUTION

A distinction must be drawn between "ethical medicines" and "generic medicines".

Ethical medicines are medicines which patented and may not be manufactured and marketed by anyone other than the holder of the patent. Once the patent has expired other manufactures may make and market similar products under a different trademark, these are known as generic medicines and are considerably cheaper than their original.

A pharmacist has a duty to:

1. inform all patients presenting a prescription of the benefits of the generic or "interchangeable multi-source medicine".
2. dispense a generic, unless the patient has expressly forbidden substitution. This prohibition must be noted on the script. If the generic is dispensed it must so be noted.

A pharmacist may not dispense a substitute in the following three instances (section 22 of the Medicines and Related Substances Act):

1. the doctor has written, "no substitution".
2. the retail price of the generic is higher than the original
3. if the generic has been declared "non-substitutable"

"BONUSING" AND "SAMPLING" OUTLAWED "promote medicines"

A medical practitioner may not accept or get from any pharmacist any commission or reward in connection with any prescription given. = A criminal offence and will lead to disciplinary action.

Bonusing: supply of medicines according to a bonus system, rebate system or any other incentive system".

Sampling is "the free supply of medicines by a manufacturer or wholesaler or its agent to a pharmacist, medical practitioner, etc." The prohibition does not include a free supply of medicines for the purpose of clinical trials.

QUESTIONS

Write a note on the statutory provisions regarding the substitution of medicines prescribed for a patient by a doctor, with generic medicines

A distinction must be drawn between "ethical medicines" and "generic medicines".

Ethical medicines are medicines which patented and may not be manufactured and marketed by anyone other than the holder of the patent. Once the patent has expired other manufactures may make and market similar products under a different trademark, these are known as generic medicines and are considerably cheaper than their original.

A pharmacist has a duty to:
1. Inform all patients presenting a prescription of the benefits of the generic or "Interchangeable multi-source medicine".
2. Dispense a generic, unless the patient has expressly forbidden substitution. This prohibition must be noted on the script. If the generic is dispensed it must so be noted.

A pharmacist may not dispense a substitute in the following three instances:

1. The doctor has written, "No substitution".
2. The retail price of the generic is higher than the original
4. if the generic has been declared "non-substitutable

The statutory provisions governing the giving of a commission to a doctor prescribing a certain medicine and the so called bonusing and sampling in connection with the supplying of medicine by wholesalers and manufacturers.

A medical practitioner, dentist, etc. may not accept or obtain from any pharmacist any commission or other reward in connection with any prescription given. Contravention of this amounts to a criminal offence and will lead to disciplinary action.

Bonusing and Sampling
"Bonusing" refers to the supply of medicines according to a bonus system, rebate system or any other incentive system". "Sampling" is "the free supply of medicines by a manufacturer or wholesaler or its agent to a pharmacist, medical practitioner, etc." The prohibition does not include a free supply of medicines for the purpose of clinical trials.

Write a note on the dispensing of medicines by practitioners

Doctors, dentists etc. have a limited right to compound or dispense medicine. In terms of S52 they may only do so on the authority and subject to conditions of a Director-General of Health. A licensed practitioner may not keep an open shop or pharmacy. "Open shop" – where the supply of medicines to the public is not done by prescription.

Requirements and limitations include:
- Practitioner must have completed a supplementary course under the Pharmacy Act.
- A license may be issued "on the prescribed conditions"
- An application fee is payable
- The license is valid for a prescribed period and must be renewed. A fee is also payable
- The Director-General can revoke or suspend a license on grounds such as failure to comply

The issuing is governed by Government Notice. A formal application must be made, where the applicant must advertise his intention to apply for such license in a newspaper circulating the relevant area.

In considering the application, regard must be given to:
- The existence of other licensed facilities in the vicinity
- Representations made by other interested parties
- The geographic area to be served by the applicant
- Demographic considerations, including disease patterns and health status of users to be served

A license will be valid for three years. Thereafter it needs to be renewed periodically.

LEGISLATION AND ITS EFFECT ON MEDICAL LAW

THE PROHIBITION OF UNFAIR DISCRIMINATION

S9 of the Constitution (equality clause)**:** Prohibits unfair discrimination on numerous grounds including:

- "disability", e.g. epilepsy

This includes denying a disabled person any supporting facility necessary for her functioning in society.

The Promotion of Equality and Prevention of Unfair Discrimination Act has given effect to the above provision by prohibiting discrimination on the basis of a disability. It further states that HIV/AIDS is considered a disability and is a prohibited ground of discrimination (**S34**)

Examples of unfair practices in the health care sector contained in the latter Act include:

- subjecting persons to medical experiments without their informed consent
- unfairly denying or refusing any person access to health care facilities or failing to make facilities available
- refusing to provide emergency medical treatment to persons of particular groups
- refusing to provide reasonable health services to the elderly

NHA – Section 20 prohibits unfair discrimination against health care personnel on the grounds of their health status.

THE RIGHT TO LIFE – S11 of the Constitution

In *Christian Lawyers Association* the court held that the Termination of Pregnancy Act governing abortion was not in conflict with the constitutional right to life.
Authors have argued that the duty in terms of section 11 is to promote the sanctity of human life which could include foetal life.
Author Naude criticises the finding in the Christian Lawyers case. He states that the state has a duty to promote the right to life. Author Slabbert argues that the duty of state to ensure that human life is respected and valued. The duty to promote the so called "sanctity of human life".

In Stewart v Botha the SCA rejected the action for a wrongful life by stating that to choose no life above life as a disabled person violates the sanctity of human life.

With regard to euthanasia: it is unlawful to assist someone to commit suicide and take part in active euthanasia.

THE RIGHT TO FREEDOM AND SECURITY – S12 of the Constitution

The right to bodily and psychological integrity includes:

- The right to make decisions about reproduction: *(including sterilization and abortion – as found support in the Choice on Termination of Pregnancy Act)*
- Security and control over your body
- Not to be subject to medical experimentation without informed consent

This right is linked to a doctors duty to get informed consent.

Xaba: a police officer isn't allowed to use violence to get the surgical removal of a bullet from the leg of a suspect for the purposes of evidence as this is in breach of this section.

If a doctor preforms surgery on a patient without obtaining informed consent, he infringes this section 12 right (Mc Donald v Wroe).

THE RIGHT TO PRIVACY – S14 of the Constitution

S14 deals with one's right to privacy in general terms.
In terms of our common law, a patient has a right to expect that the doctor doesn't disclose his ailments and treatment
S14 of the Constitution will probably have little impact on the field of medical law due to the above mentioned common law right.

S14 National Health Act: all information regarding a patient's health, treatment and stay at an institution may not be disclosed unless:

1. Patient consents in writing
2. Court order allows for it
3. It amounts to a threat to public health

In NM v Smith it was held that publication of three people's names and HIV status in a bibliography amounted to a breach of this right.

In Tshabalala-Msimang v Makhanya, the then Minister of Health was admitted to a private hospital for treatment. The respondents (editor, journalists and owner of the Sunday times) published an article elaborating on the Ministers treatment. In this report it was alleged that the Minister abused her powers while in the hospital and transgressed some of the hospital rules. It further stated that she overindulged in alcohol. The Minister and the hospital approached the court for an order to claim the return of the Ministers health records from the respondents. The Minister contended that the respondents had contravened her section 17 right in the NHA. The court found that a person's medical records are private and confidential and any disclosure amounts to an infringement of one's right to privacy.

THE RIGHT TO HEALTH CARE – S27 of the Constitution

(1) everyone has the right to have access to health-care services, including reproductive health care (public)
(2) the state must take reasonable legislative and other measures within its available resources to achieve progressive realization of these rights.
(3) no one may be refused emergency medical treatment (public or private)

This (3) was questioned in the following cases:

In Soobramoney the court held, when a person suffers a sudden catastrophe which calls for immediate medical attention. – Here, the patient suffered from kidney failure which could be prolonged by means of regular rental dialysis. Patients with irreversible chronic kidney failure were not automatically admitted to the programme.
The cost would be too high and the patient's condition was not serious enough.
Emergency medical treatment did not include ongoing treatment to prolong s life.
The Constitutional Court found that the duty placed on the state depends on the means available for such purposes and that corresponding rights are also limited on account of lack of means. They held that "emergency medical treatment" did not include ongoing treatment of chronic diseases in order to prolong life.
The court held that the patients claim should rather have been considered under section 27(1) and (2) and not (3) as there was no "emergency".

In Treatment Action Campaign and others v Minister of health and others, the applicants wanted Nevirapine dispensed in all hospitals to mothers who are pregnant with HIV. The High Court held that with Nevirapine it is affordable if the programme is properly planned. On confirmation in the Constitutional Court, it was held that it was not a complex task and that reasonable measures would need to be taken to extend testing and counseling and that by making it available to reduce the risk of mother-to-child transmission of HIV.
This was confirmed in The Minister of Health and Others v Treatment Action Campaign by the Constitutional court.

S5 NHA states that "A health care provider, health worker or health establishment may not refuse a person emergency medical treatment". – there is nothing in this provision which entitles a patient to such treatment free of charge.

THE RIGHTS OF CHILDREN – S28 of the Constitution

The Constitution states that any matter involving a child must be in a child's best interest. (*Hay v B*)

Section 28(1)(c) refers to the child's right to health care services and section 28(1)(b) refers to the child's right to parental care or if removed from same to appropriate alternative care.

In Grootboom the court stated that these two sections should be read together.

The case of Treatment Action Campaign dealt with the rights of children. The court held that the state is obliged to ensure children enjoy the protection granted in terms of section 28 which arises when parental care is not realized.

THE RIGHT TO INFORMATION – S32 of the Constitution

Everyone has the right of access to:
(a) any information held by the state
(b) any information held by another and is required for protection of any rights.

This clearly entitles patients access to their medical records.

The Promotion of Access to Information Act was enacted to give effect to this right.

Medical And Health Records

Doctors must make comprehensive and detailed notes in a patient's medical records.

The National Health Act requires that hospitals and other health establishments keep detailed records (s13). It further requires confidentiality of patient information (s14).
S15 deals with ones rights to access to health records and s16 deals with access to health records by health care providers.

S16: rights given to doctors to see the health care records for:

- Treatment of the patient
- Study, teaching or research with authorization of the patient unless no information as to the patients identity is revealed.

S17 deals with the protection of a person's medical records (Tshabalala-Msimang)

Discharge Report

S10 of NHA states that a patient must be supplied with a discharge report. This report may be verbal in the case of an outpatient but must be written in the case of an inpatient.

Patients Duty To Comply With The Rules

A patient must comply with the rules of the institution and further provide all health care practitioners with complete information.
If a patient refuses treatment, he must sign a certificate of release of liability (s19 of NHA).

THE RIGHT TO JUST ADMINISTRATIVE ACTION – S33 of the Constitution

The right to administrative action that is lawful, reasonable and procedurally fair, including the right to be given written reasons.

The Promotion of Access to Information Act was enacted to give effect to this right.

THE RIGHTS OF PRISONERS – S35 of the Constitution

This includes the rights of arrested, detained or accused, which includes the right to medical treatment at state expense and the right to be visited by a chosen medical practitioner.

In Van Biljoen and others v Minister of Correctional Services, it was held that the state has a higher duty of care to HIV prisoner's than to citizens as they have no access to other resources enabling them to gain access to medical treatment. HIV prisoners are more exposed to opportunistic viruses than other people with HIV who are not imprisoned. Once a prisoner has been prescribed an anti-viral treatment for AIDS, he is entitled to continue receiving medication, but the decision to originally prescribe it is a medical not a legal question. The court stated that the supply of antiviral drugs is a medical question and should not be asked of law.

S37 says that in a state of emergency the detainee has the right to choose and be visited at any reasonable time by a medical practitioner.

QUESTIONS

Write notes on the following:

- **The patient's rights to information regarding his medical and hospital records**

Include S32 and Promotion of Access to Information Act

- **The rights of prisoners to medical treatment**

Include S35 and S37 and Van Biljoen and others v Minister of Correctional Services

- **Unfair discrimination**

Include S9 if the Cn and the Promotion of Equality and Prevention of Unfair Discrimination Act – S34 with the list of examples

- **The right to individual health care**

Include S27 of the Cn and the cases of Soobramoney and Treatment Action Campaign and others v Minister of health and others, and then also include S5 of the National Health Act.

- **The constitutional right to emergency medical treatment**

Include S27 of the Cn and the cases of Soobramoney and Treatment Action Campaign and others v Minister of health and others, and then also include S5 of the National Health Act.

- **The right to life**

Include S11 and Christian Lawyers Association.

- **The right to freedom and security**

Include S12 of the Cn and Xaba

- **The right to privacy**

Include S14 of the Cn, common law and S14 of the National Health Act

- **The rights of children**

Include S28 of the Cn and Hay v B

- **The right to just administrative action**

Include S33 of the Cn and the Promotion of Access to Information Act.

THE LEGAL BASIS OF MEDICAL INTERVENTION

CONSENT AS GROUND OF JUSTIFICATION

A duty to heal

A physician is under a general duty to act and to treat a patient. Although such a duty is not expressly imposed by the Oath of Hippocrates. This oath contains a positive purport with regard to the practice of medicine. According to the Geneva Declaration of 1948 (modern version). The physician must solemnly swear these words: "I shall treat human life with the greatest respect, even where I am deceived, I shall not exercise my knowledge of medicine in conflict with laws of humanity."

In an emergency a doctor must stabilize the patient and thereafter provide a suitable referral.

A professional right to heal

The extent to which a physician may act in his treatment, may depend on what legal ground medical intervention is based.
Consent will justify medical treatment. The question of the legal basis of medical treatment is concerned where it is against the will of the patient, or where he is incapable of expressing his will at all.

There are 3 elements which have to be present for consent to be legally valid: knowledge, appreciation and acquiescence.
Further a person must be properly informed before his consent is regarded as legally valid (informed consent). Therefore the providing off the required information must precede the act of consent.

For consent to be valid it must:

- Not violate the good morals of society (can't be consent to CH, criminal abortion, reproductive cloning, reckless experiments or unlawful organ donations)
- Be given in the proper form as prescribed by law (written consent is required for sterilization, surrogacy, removal or tissue, blood or gametes, child consents, virginity testing, circumcision, abortion or donation of gamete)
- Be given voluntarily
- Be clear and unambiguous
- Be comprehensive
- Encompass all three elements of consent
- Be given by someone legally capable of consenting

The maxim, ***volenti non fit iniuria,*** "no injustice is done to him who is willing" is used. This simply means that it is not a crime if it is consented to. Consent must be in accordance with the legal convictions of the community.

THE CONCEPT OF CONSENT

There are two requirements that are needed, firstly, consent must be given and secondly, it must be informed consent.

The patient can consent expressly, that is in words, either orally or in writing. Consent in writing is subsequent proof and is desirable in the case of serious procedures. Consent for a specific form of treatment can take place by means of a mere tacit submission to the treatment. Consent can be expressed or implied.

Liability on consent – DUTY TO ACT (boni mores)

Traditionally, a person could not be held liable by virtue of a mere *omissio*. Today it is accepted that a mere *omission* would lead to liability where the person concerned could reasonably be expected to intervene. (Russell and Ewels)

The ethics of the medical profession (ethical guidelines of the HPCSA) place an obligation on a doctor to assist in an emergency situation within the parameters of their practice, experience and competence. If they can't assist then the guidelines provide that they refer the patient to a colleague but if it is an emergency they are obliged to first stabalise the patient.
If there is an existing doctor-patient relationship, the doctor must at all times act in the patients best interest and must be available to their patients if they are on duty.

The criterion to determine whether a doctor should act is, therefore the *boni mores* test. (the legal convictions of the community)

A physician will be criminally liable if he fails to act in any situation besides:

1. Services of a specialized nature.
2. Where a physician might doubt his own ability.
3. He may have so many patients already that in their interests he ought not reasonably be obliged to accept anymore.
4. He may at the time in question be in a state of such utter exhaustion that it would be unreasonable to make demands on him.

When is there a legal duty to act positively?

1. **Prior Conduct**: where the perpetrator, by a positive action, creates a potentially dangerous situation, and then later neglects to take precautions to avert the danger (*commissio per omissionem*). E.g. where a physician starts treatment which needs to be continued and he doesn't – he will be delictually and criminally liable.

2. **Control of a Dangerous Object**: where a person accepts control of a dangerous object or situation and fails to exercise proper control over it. E.g. A, a physician, is giving a blood transfusion to C. He is urgently needed somewhere and asks B, a colleague to take control temporarily.

B fails to exercise proper control and C dies. B may be criminally and delictually liable.

In Seema v Executive Member, Gauteng a gravely disturbed patient was admitted to the hospital where the defendant was in charge. The patient was moved from a security ward to an ordinary ward and there was no security fence around the hospital premises. The dangerous patient escaped, kidnapped the plaintiff's daughter and raped her. The court held that there was a legal duty to protect the boarder public against unlawful conduct by patients and the court awarded damages to the Plaintiff.

In *Magware v Minister of Health NO (1981)*, medical staff incorrectly applied a plaster of paris cast, and then further were negligent in the following aspects: they failed to check the fracture dislocation by means of an x-ray immediately, when later taken the x-ray revealed that the dislocation was in an unacceptable position and required immediate correction, which they failed to provide. The court held that the staff had a duty to complete the treatment as they had commenced treatment and ought to have completed it.

3. **Statutory Authority**: where an obligation to act is imposed on a person by a specific statutory provision. Section 27(3) states that no one be refused emergency medical treatment. Whether public or private, a physician has a duty to act unless he has complete and compelling reasons to refuse. Soobramoney

4. **Contractual Liability**:
   (a) When a doctor is employed by a hospital: a legal duty can arise from a contract of employment. The scope of a physician's duty is dependent on the employment contract.
   (b) When a doctor is in a private practices: a duty to act arises when patients have a contract with the physician. A breach can make the physician criminally, delictually and contractually liable.
   Edouard

Where a patient consults a doctor who undertakes to treat him, the doctor assumes no greater duty than to treat the patient with due care and skill. If the doctor has expressly guaranteed that the patient will be healed by his treatment, he will then be liable.

A DOCTOR'S DUTY TO INFORM THE PATIENT

The question asked is how much must a doctor tell his patient about the risks involved in the treatment.

In Castell v De Greef the question was asked how much information must a patient be told. It was held that informed consent is needed.

In McDonald v Wroe 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 a patient to surgery without his informed consent is a violation of one's bodily integrity.

It is said that although there is no need for the doctor to point out all the conceivable complications that may arise, he should at least inform the patient of the serious risks involved in the operation. E.g. amputate his penis (Elliot), fractures of pelvis from electroshock (Botha). Where the risk of a particular form of treatment is extremely uncommon the doctor cannot be held liable for failure to mention such possibility to the patient (Richter).

The NHA contains important provisions on informed consent which includes that the patient be informed of the cost of every treatment.

The Doctrine of informed consent is covered by common law and statutory law.

Author Van Oosten did and in depth study on the common law concept of informed consent. He stated that it could be expected that a doctor give the patient a general idea in broad terms and layman's language of the:

- nature,
- scope,
- consequences,
- risks,
- dangers,
- complications,
- benefits,
- disadvantages and
- alternatives

to the suggested intervention. (different to legislation which includes costs)

If any remote risks are serious (death, paralysis etc.) they must be communicated to the patient.

The National Health Act: informed consent reinforced the common law position
Section 6: a doctor must inform the patients of his right to refuse treatment as well as the benefits, risks, costs and consequences of the treatment.
There is also a duty on the doctor to inform a patient who refuses treatment on the implications and risks inherent in his refusal.

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

The doctor has no obligation to inform the patient when:

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

The defence

The defence that can be used when informing the patient on all the material risks, is where it would have a harmful effect upon the patient to inform him of the diagnosis or potential effects of treatment, e.g. where a cancer patient will become despondent and may develop suicidal tendencies, it is not necessary for the doctor to inform the patient. The term *"therapeutic privilege"* is used in connection with this.

Castell confirmed the duty to inform a patient is subject to the therapeutic privilege.

This defence is afforded limited recognition in both the Mental Health Care Act and the National Health Act.

Section 13(3) of the Mental Health Care Act provides that a mental health care provider may temporarily deny a mental health care user access to information contained in his health records if disclosure of that information is likely to seriously prejudice the user or cause the user to conduct himself in a manner that may seriously prejudice him or the health of other people.

The NHA has given express but limited statutory recognition to therapeutic privilege in requiring the doctor to inform the patient unless it would be contrary to the best interests of the patient (section 6).

Author Coetzee states that this defence has been criticised before and therefore is off the opinion that it should only be applicable when all the requirements for necessity have been met but ought not be used where the intervention is against the wishes of the patient.

Examples of the defence:

- In VRM v Health Professions Council of South Africa and Others, a woman tried to institute action based on the fact that the doctor did not inform her when she was 8 months pregnant that she was HIV positive and only did so when the baby was still born. The doctor's defence of therapeutic privilege was upheld.
- where a cancer patient would probably become so discouraged when fully informed of her situation that her treatment may be prejudiced.
- giving seriously bad news to a depressed patient with suicidal tendencies.

Case decisions on informed consent

In the Richter case a young married woman had fallen on a sharp edge of a chair and for the second time injured her coccyx. The defendant, a neurosurgeon gave her an injection which had unfortunate consequences for her including, loss of bladder control, loss of sexual feeling and loss of power in her right leg and foot. The plaintiff alleged that the defendant had been negligent in not warning her about the possible consequences. Based on evidence given by two other doctors, in that the consequences were extremely uncommon, the court held that the defendant had not been negligent.
The court held that conduct should be tested by the standard of the reasonable doctor faced with the particular problem. 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 do. (Expert evidence)

In Castell v De Greef, 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. A risk is material if, in the circumstances of a particular case:

1. the reasonable person in the patients position, if warned of the risk, would be likely to attach significance to it, or
2. the doctor is, or should be reasonably aware that the particular patient, if warned of the risk, would be likely to attach significance to it.

This obligation is subject to the so-called therapeutic privilege.

Although expert medical evidence would be relevant in determining the risks or result, it is not a question that is to be concluded on the basis of medical evidence alone. The ultimate decision will be that of court of law.

In Broude v McIntosh and Others, the court declined to express itself on the correctness of the judgment in Castell. They held that they could not use the reasonable doctor or patient test because the patient was a doctor and one could assume he would have a certain percentage of knowledge and would know what to ask. However, the court still followed Castell but did not want to confirm it as the correct way. In Broude the patient had suffered from deafness and a buzzing in the year. He underwent surgery to correct this which alleviate the condition but left him permanently deaf in his left year. 20 years later the symptoms reoccurred and was operated on by the defendant. Post op the plaintiff experiences facial paralysis on the left side. He sued the defendant as the doctor failed to inform him of the risk of leakage of cerebrospinal fluid. The court held the leak was not connected to the facial paralysis.

In Jacobs, the plaintiff wanted to sue for damages after there was a leakage of cerebrospinal fluid during a surgery intended to relieve the patients chronic sinus, the court, relying on Castell, found that it was sufficient for a doctor to indicate the bodily parts and the "danger areas" that might be affected and indicate that the required care would be exercised. The claim failed.

From these cases it is clear that informed consent is needed. In Unisa's view, doctors should be guided by the reasonable-patient test as expounded in the well-reasoned Castell judgment.

In Oldwage v Louwrens, the patient experienced severe pain in his right leg. After being examined the defendant, a vascular surgeon diagnosed the situation as a blockage and preformed an operation. The plaintiff was still not relieved and underwent further surgery at the hands of a neurosurgeon. After the second operation the plaintiff experienced pain in his left leg. The court found that the patient had been misdiagnosed and was further not counselled properly prior to the treatment and there was therefore no proper informed consent.

The court confirmed the Castell "material risk" test. The court found, the patient had not been properly counselled prior to the operation of options and material risks. There was no proper informed consent and the surgeon's conduct constituted assault.

On appeal (Louwrens v Oldwage), the court refrained from unequivocally confirming the correctness of the test.

It is decided that the wise doctor will ensure that he does not overestimate the patient's intellectual level, and will avoid technical terminology in describing to the patient the nature and scope of the operation and any serious consequences or complications that may result from it.

In McDonald v Wroe confirmed the criterion of materiality as the standard to be applied. In this case a woman visited the dentist for problems with his wisdom teeth. He advised her that 3 of her impacted wisdom teeth had to be extracted under anaesthesia. She suffered permanent damage and instituted action.
The court found that she could not prove that the defendant did not have the necessary skill to perform the operation.
The Defendant concealed that he did not warn the plaintiff of the risk of permanent nerve damage but alleged that she would have undergone the operation even if informed of the risk. The court found that she would have preferred to have the operation done by a specialist surgeon and therefore the defendant was causally responsible for the plaintiff's damage.

Testing (HIV etc.)

A health personnel taking urine or blood specimens from patients who seek medical advice or treatment, need not inform them what these specimens will be tested for, unless the patient insists on being told. However, if the taking of a specimen is for the purpose of testing it for HIV the patient needs to be informed thereof. Such a test should be preceded by adequate counseling. (C v Minister of Correctional Services)

Should a test for HIV be positive, a legal obligation arises to inform the patient and to council him properly, considering the fact that AIDS is a deadly, incurable and infectious disease.

HIV testing in the work place

Concerning HIV testing and employment, the Employment Equity Act prohibits such testing of an employee unless it is determined to be justified by the Labour Court.

In Rand Water Board v SAMWU Others the court emphasized the need for informed consent. The court ruled that HIV testing of employees was permitted for a restricted time under the following conditions:

a. On a voluntary basis with informed consent
b. Testing will not be requested as a condition of employment, promotion or for any other benefit
c. Testing will not be a job requirement
d. No prejudicial inference will be drawn from a refusal to submit to testing.
e. Testing will only be done after pre-test counseling has been given and will be followed by post-test counseling
f. The contractors conducting the testing will at no time reveal the results of the test to anyone but the employee
g. The contractors will be required to sign a confidentiality agreement
h. 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 2003 in Irvin & Johnston Ltd the court stated 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 a court's permission.

Doctor deviating from operation consented to

The general rule is that a doctor will not be entitled to materially deviate from treatment agreed upon, in any event not where the treatment given is far more radical than that consented to.

But where a patient has consented to a specific type of operation and whilst he is being operated upon, under a general anaesthetic, another serious

condition is detected in circumstances where it would have been impossible to have been made by a reliable diagnosis previously, the doctor may be justified in trying to remedy such condition, provided:

1. that such extension of the operation is in accordance with good medicine
2. that the extension takes place in good faith in order to alleviate the patient's complaint
3. that the risk to the patient is not materially increased
4. that it would be contrary to the patient's medical interests to first allow him to recover from the anaesthetic in order to give consent to the operation's being extended

Treatment without consent

Every operation preformed without consent isn't necessary unlawful. Where a patient is mentally ill or temporarily incapable of volition, the intervention may be legally justified on other grounds. But where the operation takes place against the will of the patient, it will be unlawful unless it is in public interest and safety.

Grounds of justification to medical treatment where consent is lacking in terms of common law include:

1. Necessity and negotorium gestio
2. Statutory authority (emergency, public safety)
3. Court order

Common law makes provision for treatment without consent in the case of an emergency.

S7 NHA confirms treatment without consent in the case of dire emergency provided that the patient has never expressly refused such treatment.

Section 7(1) of the NHA allows for medical intervention without a party's consent where:

- It is authorized by any law
- It is authorized by a court
- failure to treat might result in a serious risk to public health
- any delay might result in the person's death or irreversible damage.

Statutory Authority: this occurs where:

- there is failure to treat the patient which poses a serious threat to public health
- taking blood samples which may be relevant in criminal proceedings
- authorizing the examination, hospitalization and treatment of a person suspected of having a communicable disease
- authorizing compulsory immunization in certain circumstances.

In Minister of Health, Western Cape v Goliath an application was brought in public interest where the respondents had been diagnosed with a highly infectious drug resistant tuberculosis. They argued that such detention would infringe their right to freedom. The court found that such limitation was justifiable.

Medical intervention without consent in emergencies

There are various views as to consent in emergency treatment and the grounds of justification involved. There are two grounds recognized at common law:

1. *Emergency ("necessity")* is in fact regarded as a ground of justification. However, here the interests of an innocent third party are sacrificed to protect the interests of the person threatened. The person threatened (the patient) is generally also the person in respect of whom the "protective act" occurs, therefore no third persons interest is sacrificed. Necessity will be the ground of justification where the medical treatment of a person is administered directly in the interests of society at large, e.g. an outbreak. This can be raised where action is taken against a patient's will.

2. *Negotiorum gestio* is the ground of justification in our common law which relates to the interests of a patient and not to the interests of society. It was concerned with the protection by one person of the patrimonial interest of another but there is no reason why this should not be extended to a situation where the party who is "threatened" is physically present but psychologically "absent" due to unconsciousness, etc. further there is no reason why *negotiorum gestio* cannot also include the protection of the interests of personality (extended to non-patrimonial interests). 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 on an unconscious patient he may avert grave complications which might later cause the patient's medical expenses to be high.

   The requirements of *negotiorum gestio* are:

   a. Necessity for the intervention must exist.
   b. He dominus must be incapable of consenting
   c. It must not be against the dominus' will
   d. The gestor (doctor) must promote the interests of the dominus (patient) without the latter's authorization and knowledge of such promotion.

   If a doctor has done what is reasonable in an emergency, he cannot be held liable if the emergency measures prove to be of no avail and the patient dies.

   The gestor is entitled to remuneration and has the right to recover damages for injury.

Where treatment occurs without the consent of the patient and where neither the traditional situation of necessity nor *negotiorum gestio* is present. In a situation where it is important to avoid informing the patient of his condition since such knowledge would probably affect his state of mind a doctor can rely on therapeutic measures and the physician's conduct need not be covered by any legally valid consent.

Substituted consent

Regarding consent, a person can legally consent to a medical intervention on their own body. The law does make provisions for substituted consent (section 7(1) NHA).
This section allows for consent to be given by mandate by the user in writing or by authority whether by law or court order or for consent to be given by a spouse, parent, grandparent, adult child or sibling.

If no consent is received and there is no mandate or authority granted then the following parties can consent:

- spouse
- parent
- grandparent
- adult child
- sibling

People who need consent to be given on their behalf include minors and mental health care users.

Minors

Consent on the part of a parent or guardian will normally be required (Esterhuizen).

By common law, a parent may delegate various incidents of his parental authority to a person who acts in *loco parentis*. Where a parent has expressly or tacitly authorized such a person to consent to medical treatment on his behalf, that person can lawfully do so.

Where the parents consent is not required or obtained:

- The procedure to be preformed may be so urgent that it would be unrealistic to first seek ministerial consent. The **high court or children's court**, as the upper guardian of children has the inherent power to overrule an unreasonable parental refusal. In Hay v B, where parents refused a blood transfusion on an infant which had to be administered within three to four hours, to prevent the child from dying. The doctor approached the court relying on section 28(2), the best interests of the child. This was allowed.
- In terms of the Children's Act, a **medical superintendent** of a hospital, in emergency circumstances, can consent without consulting the parent. The superintendent must satisfy two points: (1) that the

operation is necessary to preserve the life of the child and (2) that it is so urgent that it ought not be deferred for the purpose of consulting the parent. The parent or guardian is liable for the costs.

- In cases of absolute emergency where it is impractical or dangerous to request consent. Example: cardiac arrest, CPR. **The doctor, nurse or paramedic** can take immediate action without first seeking consent.
- An operation may not be performed on a **minor prisoner** without the consent of his parents in terms of section 12 of the Correctional Services Act unless it is in the interests of the prisoner's health and obtaining the parent's consent would be impossible.

To determine whether a child's consent is required we often consider either the subjective element (maturity) or the objective element (age) or both.

A child can refuse treatment if they are the correct age and comply with the maturity level but if the unreasonable then substituted consent can occur.

Medical treatment and surgery: Section 129 of the Childrens Act states that a child can consent to their own medical treatment or the treatment of his or her own child if the child is:

- over 12 years old
- of sufficient maturity to understand the benefits, risks, social and other implications

The parent, guardian or care-giver may consent to medical treatment if the child is:

- under 12 years old or
- over 12 years old but is of insufficient maturity.

Section 32 places an obligation on a person, including a care-giver, who has no parental responsibilities and rights but who voluntarily cares for the child can consent to the medical examination or treatment of a child if such consent cannot reasonably be obtained from the parent or guardian.

Section 129 further provides that a child may consent to a surgical operation for him or his child if the child is:

- over 12 years old
- of sufficient maturity to understand the benefits, risks, social and other implications
- duly assisted by his parent or guardian

The parent or guardian may consent to a surgical operation if the child is:

- under 12 years old or
- over 12 years old but is of insufficient maturity.

Consent to a surgical operation must be given in the prescribed form and signed by the child.

When a child who cannot consent to undergo an operation or medical treatment, parents refuse to consent, the Minister may consent if the parent or guardian:

- unreasonably refuses to give consent
- is incapable of giving consent
- cannot readily be traced
- is deceased

HIV Tests: Section 130 of the Children's Act states that children under 7 may consent to a test if he is of sufficient maturity to understand the benefits, risks and social implications of such a test. If the child is not of sufficient maturity, consent may be given by:

- Parent or care-giver
- Provincial head of social development
- A designated child-protection organization

A child over the age of 12 may consent to an HIV test.

Contraceptives: Children over 12 are entitled to purchase or obtain condoms.
Other contraceptives may be provided to a child over 12 upon their request without their parents consent.

Virginity tests: are prohibited on a child below 16 and may only be performed on children over 16 if their written consent is obtained (section 12).

Circumcision: is prohibited on a male child under 16 unless:

- It is performed for religious purposes (both parents consent is required)
- It is performed for medical reasons

May only be performed on a boy older than 16 if their written consent is obtained.

Circumcision of female children is prohibited.

Medical examination of victims of a sexual or violent nature: Upon the initiative of a police officer, a minor who has been a victim can undergo a medical examination where the parent or guardian (Section 335B of the Criminal Procedure Act:

- Can't be traced within a reasonable time
- Can't grant consent
- Is a suspect in respect of the offence
- Unreasonably refuses to consent
- Is incompetent due to a mental disorder
- Is deceased

A magistrate or a certain senior police officer may give consent.

Abortion: a minor female may consent independently to abortion. No age limit is prescribed by the Act. (Christian Lawyers Association). The only thing that is required is that the woman give informed consent. The intellectual maturity of the girl should enable her to appreciate the nature of the intervention. In G v Superintendent, the court refused to grant a mother's application to prevent an abortion from being performed on her 14 year old daughter who had been raped. It is doubtful that the court would be prepared to grant an application brought by the parents, to force the girl to undergo an abortion against her will.

Mental patients

Just because a person is mentally ill doesn't mean they can't consent to medical treatment. Mental illness can manifest itself in a variety of conditions, and its severity could range from mild to extremely severe. Even those with a serious form of mental illness (schizophrenia) can experience a lucid interval. When a person has a lucid interval, they can consent. Where a patient is mentally ill, a doctor must first establish whether he can or can't consent, and if needed can seek assistance from a psychiatrist.

Who can consent:

In the case of a minor patient, a parent or guardian may in terms of the Children's Act give the necessary consent. For a major patient incapable of consenting, the personal curator could, in common law, consent. This was confirmed in Ex Parte Dixie.

In this case the patient had to undergo a brain operation which was not an emergency. The court held that a curator first needed to be appointed.

From this case we can see that in the case of a non emergency operation, a patient or relative cannot legally simply give consent.

The following people may consent:

1. the curator
2. the patients spouse
3. the patients parent
4. the patients major child
5. the patients brother or sister
6. the head of the institution where the patient is
7. in cases of dire emergency, hospital doctors may consent.

Mental Health Care Act

This Act makes provision for "voluntary", "assisted" and "involuntary" care.

Voluntary care: provision of health interventions to a person who gives consent to such interventions.

Assisted care: provision of health interventions to a person who is incapable of making informed decisions due to their mental health status and who do not refuse the intervention.

Involuntary care: provision of health interventions to a person who is incapable of making informed decisions due to their mental health status and who refuse the intervention but require such service for their own protection or the protection of others.

Section 9(1) states that care may be provided to a health care user only if:

- the user has consented
- the intervention is authorized by court (Ex Parte Dixie)
- due to the mental illness, the delay in providing such intervention may result in:
  - death or irretrievable harm of the user
  - user inflicting serious harm to himself or others
  - user causing serious damage or loss of property.

For involuntary care to be considered the administrative process requires the patient to be submitted to a 72 hour assessment. The head of the institution must send a copy of the application and report to the review board within 7 days of making their decision.

A medical intervention against the will of the patient will be legally justifiable only where the interests of the state or society are involved. E.g. administration of a vaccination in order to prevent the spreading of an infectious disease.

It is important to distinguish between medical treatment without the consent of the patient and medical treatment against the will of a patient. The latter has positively expressed himself against undergoing the treatment. Except where it is done to protect the community against a threatening epidemic, a doctor is not entitled to treat a patient against his will irrespective of the reason.

Regarding patients who are on a hunger strike, the rule is that you cannot force feed them unless they become comatosed.

QUESTIONS

Discuss the duties of the doctor to inform the patient of his medical condition and the nature and effects of the proposed operation/treatment

A doctor's duty to inform the patient:
The question asked is how much a doctor tells his patient about the risks involved in the treatment.

It is said that although there is no need for the doctor to point out all the conceivable complications that may arise, he should at least inform the patient of the serious risks involved in the operation. E.g. amputate his penis (Elliot), fractures of pelvis from electroshock (Botha). Where the risk of a particular form of treatment is extremely uncommon the doctor cannot be held liable for failure to mention such possibility to the patient.

Discuss case decisions including:
Richter
Castell v De Greef, - ensure you include the two points of the new test

Ensure you state that although expert medical evidence would be relevant in determining the risks or result, it is not a question that is to be concluded on the basis of medical evidence alone. The ultimate decision will be that of court of law.

Include further comments referring to Broude v McIntosh and Others, and Jacobs,
It is NB to include the judgment and appeal courts findings in the case of Louwrens.

Discuss the defence of "therapeutic privilege".
And include the discussion on this defence with reference to case law (VRM v Health Professions Council of South Africa and Others)

A health personnel taking urine or blood specimens from patients who seek medical advice or treatment, need not inform them what these specimens will be tested for, unless the patient insists on being told. However, if the taking of a specimen is for the purpose of testing it for HIV the patient needs to be informed thereof. Such a test should be preceded by adequate counseling. (C v Minister of Correctional Services)

Can include a discussion on HIV/AIDS testing with reference to the conditions laid down in Rand Water Board v SAMWU Others

Discuss the common law principles relating to emergency treatment of a patient by a health care worker where the patient is unable to consent. Comment on the constitutional right to emergency medical treatment. Does the common law principle affected by the constitutional right?

Medical intervention without consent in emergencies
There are various views as to consent in emergency treatment and grounds of justification involved:

1. Some jurists regard implied or presumed consent as a ground of justification. The criterion would be that the patient would probably have given his consent to the treatment had he been capable of doing so.
2. In the current South African law, emergency ("necessity") is in fact regarded as a ground of justification. However, here the interests of an innocent third party are sacrificed to protect the interests of the person threatened. The person threatened (the patient) is generally also the person in respect of whom the "protective act" occurs; therefore no third persons interest is sacrificed. Necessity will be the ground of justification where the medical treatment of a person is administered directly in the interests of society at large, e.g. an outbreak.
3. Negotiorum gestio is the ground of justification in our common law which relates to the interests of a patient and not to the interests of society. It was concerned with the protection by one person of the patrimonial interest of another but there is no reason why this should not be extended to a situation where the party who is "threatened" is physically present but psychologically "absent" due to unconsciousness, etc. further there is no reason why negotiorum gestio cannot also include the protection of the interests of personality (extended to non-patrimonial interests). 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 on an unconscious patient he may avert grave complications which might later cause the patient's medical expenses to be high.

   The requirements of negotiorum gestio are:
   a. Necessity for the intervention must exist.
   b. The gestor (doctor) must promote the interests of the dominus (patient) without the latter's authorization and knowledge of such promotion.
   c. The gestor (doctor) must act with the object of serving the interests of the dominus (patient).

If a doctor has done what is reasonable in an emergency, he cannot be held liable if the emergency measures prove to be of no avail and the patient dies.
Where treatment occurs without the consent of the patient and where neither the traditional situation of necessity nor negotiorum gestio is present. In a situation where it is important to avoid informing the patient of his condition since such knowledge would probably affect his state of mind a doctor can rely on therapeutic measures and the physician's conduct need not be covered by any legally valid consent.

Include further: S5 of National Health Act and S27 of the Constitution – then state that both of these provisions confirms ones right to emergency medical treatment.

Discuss the legal principles applying to a doctor who finds it necessary to deviate from the operation agreed on, at the stage where the patient is already on the operating table and under anesthetic

- *Doctor deviating from operation consented to*

The general rule is that a doctor will not be entitled to materially deviate from treatment agreed upon, in any event not where the treatment given is far more radical than that consented to.

But where a patient has consented to a specific type of operation and whilst he is being operated upon, under a general anaesthetic, another serious condition is detected in circumstances where it would have been impossible to have been made by a reliable diagnosis previously, the doctor may be justified in trying to remedy such condition, provided:

1. that such extension of the operation is in accordance with good medicine
2. that the extension takes place in good faith in order to alleviate the patient's complaint
3. that the risk to the patient is not materially increased
4. that it would be contrary to the patients medical interests to first allow him to recover from the anaesthetic in order to give consent to the operation's being extended

Discuss the legal principles applying to consent in respect of, mentally ill patient and a minor to medical treatment or surgery

- **Minors**

Consent on the part of a parent or guardian will be required (parental power).

By common law, a parent may delegate various incidents of his parental power to a person who acts in loco parentis. Where a parent has expressly or tacitly authorized such a person to consent to medical treatment on his behalf, that person can lawfully do so.

Include the list of where the parents consent is not required or obtained what needs to occur – in this list ensure you include:
the Minister of Health,
the high court(Hay v B),
a medical superintendent
the doctor, nurse or paramedic
Heads of institutions

Discuss when a minor can consent independently

- **Mental patients**

Just because a person is mentally ill doesn't mean they can't consent to medical treatment. Mental illness can manifest itself in a variety of conditions, and its severity could range from mild to extremely severe. Even those with a serious form of mental illness (schizophrenia) can experience a lucid interval. When a person has a lucid interval, they can consent. Where a patient is mentally ill, a doctor must first establish whether he can or can't consent, and if needed can seek assistance from a psychiatrist.

In the case of a minor patient, a parent or guardian may by common law give the necessary consent. For a major patient incapable of consenting, the personal curator could, in common law, consent. This was confirmed in Ex Parte Dixie.
In this case the patient had to undergo a brain operation which was not an emergency. The court held that a curator first needed to be appointed.

Discuss the provisions of the Mental Health Care Act with regards to voluntary care, assisted care and involuntary care in this refer to S26 and S32.

Discuss the question whether, in terms of South African law, a doctor may incur liability for an omission to act. You are required to discuss whether, and if so, under which circumstances, a doctor is under a legal duty to deliver health care to members of the public. Refer to relevant case law, and cite examples to illustrate your answer.

You need to discuss the following:
Prior Conduct
Control of a Dangerous Object (*Magware v Minister of Health*) Statutory Authority
Contractual Liability

LEGALLY RECOGNISED MEDICAL PROCEDURES

Two kinds of medical procedure can be distinguished:

1. a healing (therapeutic) procedure, that is treatment of an ailing person with the view of curing him (normal medical procedures)
2. a non-therapeutic procedure which is preformed on a healthy person by the application of medical science (experiments and cosmetic surgery)

THERAPEUTIC PROCEDURES

The objective to cure

The lawfulness of a treatment undertaken with the aim of affecting a cure is beyond any doubt, provided that a ground of justification is present.

The intention to cure must be present. If an act of aggression takes place without this aim and has the effect of curing the victim of his disease, the act is unlawful.

The treatment need not be preformed by a qualified medical practitioner. Everyday life is full of instances where professionally unqualified persons give some form of therapeutic treatment, e.g. your mom cleaning a sore and putting a plaster on it.

Consent to reckless experiments with no consideration for recognized practices, is *contra bonos mores* and the treatment is consequently unlawful. Temporary injuries of an experimental kind, aimed at affecting a cure must be regarded as lawful. Infliction of serious harm is forbidden. If other recognized procedures can be effective, there is no possible justification for applying those which are unknown. Where it is possible, experimentation should rather be carried out on animals. Where the patient cannot be saved by any known means, even a dangerous experiment with little chance of success will be fully justified.

The objective anaesthesia or euthanasia

Anaesthesia

The administering of anaesthesia in order to minimize the patient's pain and discomfort during an operation is an important form of medical treatment. It may constitute negligence if ineffective anaesthesia is administered. In England, a woman was awarded damages where anaesthesia was not administered properly and she could feel everything but was unable to show it.
The administering of drugs to relieve pain where there is no longer any hope for recovery, is a lawful practice.

The question is asked when can a physician shorten a patient's life?

Williams says that such 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. Due to the resistance of 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 dosage becomes lethal.

Where a patient is suffering and no treatment can avert death but his life may be slightly prolonged by the administering of drugs, the failure of the physician's conduct to administer the drugs will not be unlawful.

Where the physician does not administer the drug with his own hand but makes it available to the patient who then administers it to himself, is **assisted suicide** and is unlawful.

Author Kahn states that the doctor who is 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.

PASSIVE EUTHANASIA

Where a person is kept alive artificially by medical means, and the doctors in attendance decide that there is no purpose in continuing resuscitative or life-sustaining measures and where such treatment is discontinued, resulting in the patient's death, the term "passive euthanasia" is used and death occurs due to an underlying illness.

The debate around these issues is known as "the right to die" debate.

The first decision relating to this debate in a South African court was handed down in Clarke v Hurst NO and Others. This judgment clarified several major legal issues relating to the withdrawal of life-sustaining treatment in a case of terminal illness and in cases of patients who are in a persistent vegetative state (PVS).

In this case, Dr Clarke, a member or the SA Voluntary Euthanasia Society, signed a Living Will before his last illness in which he suffered irreversible brain damage. He became comatosed and remained in that condition permanently.

Three years after the tragedy, his wife approached the court for an order appointing her as curator of her husband's person, with powers to authorize the discontinuance of any treatment, including any non-natural feeding or hydration.

The Attorney-general opposed the application on a number of grounds:
Firstly, by saying that the discontinuance of the artificial feeding would hasten the patient's death, thus causing it and because the applicant foresees death, would in law be liable for having unlawfully killed the patient.

In advancing this argument, he relied on the two "mercy-killing" cases of Hartmann and De Bellocq, in which it had been held that an intentional killing is murder even though the killer did not harbour any evil motive. In Clarke, the issue could only be approached after a thorough evaluation of the patient's physical and neurological deficits and the extent of intellectual life which still remains to him.

The specialist physicians who had examined the patient were in agreement that he was in a persistent vegetative state and that the damage was irreversible but he was not brain-dead.

The term "persistent vegetative" describes a neurological condition where the subject retains the capacity to maintain the vegetative part of neurological function but has no cognative function. That is a state in which the body is functioning in terms of its internal control but there is no behavioural evidence of either self-awareness or awareness of surroundings in a learned manner.

The patient does not experience pain or discomfort because he lost the capacity to experience these sensations. The judge said: "there is no doubt that the patient is still alive or that death is imminent. His life expectancy is uncertain. The discontinuance of nourishment is bound to lead to the termination of the patient's life."

His wife, the *curator ad litem*, argued that an adult, while of sound mind, is entitled to refuse to undergo medical treatment, irrespective of whether such refusal would lead to his death. Where, as in Clarke's case, while he was in sound mind, directed that should he lapse into a persistent vegetative state with no prospect of recovery, he should be allowed to die and not be kept alive by artificial means and therefore there is no reason why his curator should not have the power to give effect to his direction.

The judge refused to uphold that contention, based on the fact that the *curator personae* is at all times under a duty to act in the best interests of the patient and not necessarily in accordance with the wishes of the patient.

The judge's ruling was not decisive in the cases ultimate finding.

It was said that in the essence of the ruling that the discontinuance would not be unlawful depended on the *boni mores* of society and was held that it would be reasonable to discontinue such nutritioning.

It was also mentioned that advances in medical science have made it possible for patients to be resuscitated who would have been regarded as dead. The real danger is that by the time he has been resuscitated, his brain may be destroyed but may nevertheless be able to keep the body biologically alive. This is the situation where the doctor or the patient's family has to decide whether it would be justified to institute life-sustaining procedures.

The judge said that artificial feeding did not have any significance for the simple reason that the patient was quite unaware of it and would be equally unaware of it if it was withheld.

The judge also referred to the instance of a patient with brain damage whose heart and lungs are kept going mechanically and the doctor decides that there is no chance of recovery so he "pulls the plug". The judge said the doctor would be exempt from liability if, by the legal convictions of society, his conduct was reasonable.

In S v Williams, the victim had suffered severe brain damage and was coupled to a ventilator. The court held that the uncoupling of the ventilator could not be regarded as the cause of her death, it was no more than the termination of an unsuccessful attempt to save her life. The doctor had not killed her, but had merely allowed her to die. Another judge observed that the uncoupling of the ventilator had accelerated the patient's death and therefore in a sense caused it but it is clear that a factual causal connection is not enough to entitle legal liability.

The court was of the opinion, 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, would be justified in discontinuing the artificial feeding and would not be acting unlawfully if she were to do so.

Lastly, it had to be decided whether the steps which Mrs Clarke proposed to take would be in the best interests of the patient. The court stressed that they were in favour of the preservation of life but it is indeed difficult to appreciate a situation where the patient is in a vegetative state and would be in his best interests not to exist at all.

JUDGMENT: Mrs. Clarke was appointed as curator with the power to authorize the discontinuance of any treatment. It is noted that it would not be necessary in all cases for a *curator personae* to be appointed. The finding was that discontinuance of treatment in this case would not be wrongful.

The essence of the ruling in this case was that discontinuance of medical treatment in the circumstances would not be unlawful. The decision was based on the boni mores of our society and whether the discontinuance of the artificial feeding which would result in death would be unlawful. The court found that in this case it was reasonable to discontinue the feeding as judgment is based on the quality of life that the patient still enjoys.

ACTIVE EUTHANASIA

The causing of death by a positive action, is unlawful in principle. Consent to homicide is no defence. (S v Robinson)
We look to case law to determine if active euthanasia is allowed:

In R v Dawidow, the accused was found not guilty of murder where he shot his painfully suffering mother to release her from her suffering. The accused was found not guilty of murder as he lacked criminal capacity (not because his act was lawful or justified).

In S v De Bellocq, the court dealt with the case of euthanasia where there could be no request or desire on the part of the sufferer. Here, a mother, in a state of emotional shock and deep depression, drowned her child in a washbasin, who was suffering from an incurable disease (toxoplasmosis). She was accused and found guilty of murder but was not sentenced.

Euthanasia is unlawful whether it takes placed at the request of the sufferer or otherwise. If a medical practitioner were to take positive steps so as to cause the hastening or immediate death, he would consequently be guilty of murder.

In S v Hartmann, a medical practitioner took the life of his ailing father (cancer) by administering a considerable dosage of morphine and pentothal. The court held that the accused was guilty of murder because it was unlikely that the father ad expressed a wish to die. The judge held that there were strong mitigating factors and sentenced the accused to a suspended term of imprisonment of one year.

According to South African judgment, to hasten death is to cause it. In R v Makali, the court declared that the true enquiry is whether the deceased would have died when he did but for the accused's unlawful act (factual causation).

If the doctor makes the drug available to the patient and the patient then administers the drug, it is said that there is no difference between administering and supplying the drug.

DOCTOR SUPPLIES HARMFUL SUBSTANCE TO A SUICIDE PATIENT - ASSISTED SUICIDE

If the physician makes the harmful medicine available in circumstances, which would make death a likely consequence, the existence of a causal connection ought to be accepted, and the liability of the practitioner ought to depend on his fault.

Assisted suicide is governed by our common law and falls within the definition of murder.

If the doctor foresaw that the patient might use the substance to commit suicide and reconciled himself to the possibility, the doctor may be guilty of murder. If the doctor did not foresee the suicide or did not reconcile himself to the possibility but the reasonable person in his position would have foreseen then he could be guilty of culpable homicide.

One can't argue that since suicide is not a crime in our law it is not unlawful to assist a person to commit suicide. Joint causation of the death of another is always unlawful. There is, a significant difference between an act intended to terminate one's own existence, to terminate the existence of another. E.g. if a physician makes poison available, thinking it to be harmless, he will be found guilty of culpable homicide. Indications in our case law show that the supplying of a harmful substance to an intended suicide is not punishable as murder or culpable homicide.

In S v Gordon, the accused was acquitted on the charge of murder where he and his mistress had entered into a "suicide pact". He gave her the drugs; she took the tablets and subsequently died. Her act was, according to the court a *novus actus interveniens* and the accused's conduct was not the cause of her death.

The decision in Gordan was, in Unisa's respectful opinion, open to criticism and the perpetrator should have been found guilty of murder or at least culpable homicide.

In R v Matthews, the accused was found guilty of culpable homicide where he supplied the deceased, who was already under the influence of liquor, three glasses of sherry, and persuaded him to drink them in quick succession. As a result of this, the deceased died. The accused was the employer of the deceased and had exercised authority over him.

Authority now stands from the decision in Grotjohn. Here the court supported the view that a person, who assists another in committing suicideor consciously encourages another to commit suicide, may be guilty of murder or culpable homicide. In this case X supplied Y with the means to commit suicide (shot gun) and was therefore found to have assisted her and had contributed to her death.

"Dr Death"

The legal issues involved in a doctor's assisting a severely suffering patient with a terminal illness who wishes to end his own life. Dr Jack Kevorkian, dubbed "Dr Death", from Michigan, USA, developed an apparatus, which could be connected to the patient by way of an intravenous needle. If the patient pushed the button, an anesthetic substance would be fed into his bloodstream followed by potassium chloride, which would result in the patient's death within minutes.

Kevorkian was indicted for murder but the court held that Michigan had no law making it a crime to assist suicide.

In 1999, by the time Kevorkian had assisted 130 suicides he was charged with murder once again after giving an ailing patient who desired to die, a lethal dosage of drugs. He had injected the patient himself while the procedure was recorded on videotape. He was convicted of second-degree murder.

During the 1990s the legislature of the Australian Northern Territories state enacted legislation to legalize doctor-assisted suicide within certain narrow limitations.

In 2001 the Dutch parliament passed an Act which declares doctor-assisted suicide in extreme cases lawful. The requirements are very strict:

1. the doctor must be satisfied that the patient's suffering is unbearable and
2. there is no prospect of improvement.

Other countries who have legalized it include Switzerland and Belgium.

A NEW APPROACH TO EUTHANASIA

The South African Law Commission made no recommendation on voluntary active euthanasia but proposed the following three options:

- that the present provision of prohibiting voluntary active euthanasia be confirmed
- that voluntary active euthanasia be regulated by legislation and a doctor be allowed to comply with the request of a terminally ill but mentally competent patient to end his unbearable pain
- that active euthanasia be regulated by legislation where the final decision rests with a panel or committee who have to comply with a specific criteria

The SA Law Commission also proposed that a living will enjoy legal recognition with regards to passive euthanasia.

According to authors Carstens and Pearmain, it seems as if the underlying values and spirit of the Constitution support the acceptance of voluntary active euthanasia based on a person's rights to dignity, freedom of a person, privacy and access to emergency medical care.
Recognition of voluntary active euthanasia recognizes the right of freedom of choice which allows people to take control of their own bodies. It has been stated that this choice should only be given to terminally ill patients who, due to unbearable and untreatable pain and loss of dignity their lives are no longer of value and who repeatedly and actively seek help with suicide. Such people must be mentally competent and not suffer from depression.

Contrary to this, authors Malherbe and Venter argue that the current position and views in South Africa regarding active euthanasia and assisted suicide as being criminal offences is correct and should not be amended.

QUESTIONS

Discuss withholding treatment from a terminally ill person on the basis of her having signed a living will.

In this question you need to discuss passive euthanasia – start of by defining it and define what is a living will. Then refer to the leading case in SA on it - Clarke v Hurst NO and Others. In discussing this case ensure that you include the following:

- Brief set of facts ensuring you include who Dr Clarke was and what he did during his life.
- The attorney general's argument
- Dr Clarkes wife's argument
- That the judge referred to S v Williams, - what happened here and the courts findings on this case.
- The court's JUDGMENT

Then give your own opinion on the status and validity of a living will in SA

Write a note on doctor assisted suicide

Here you need to discuss the element where a doctor supplies harmful substance to a suicide patient

It is another matter if the physician makes the harmful medicine available in circumstances which would make death a likely consequence the existence of a causal connection ought to be accepted, and the liability of the practitioner ought to depend on his mens rea.

The argument that the deceased would in any case have acquired the fatal substance elsewhere is without substance. The existence of a causal connection is not dependent upon other hypothetical causes, and speculation of this kind is not juridically relevant.

It is inadmissible to argue that, since suicide is not a crime in our law it is not unlawful to assist a person to commit suicide. Joint causation of the death of another is always unlawful. There is, a significant difference between an act intended to terminate one's own existence, to terminate the existence of another. E.g. if a physician makes poison available, thinking it to be harmless, he will be found guilty of culpable homicide. Indications in our case law show that the supplying of a harmful substance to an intended suicide is not punishable as murder or culpable homicide.

Include in your discussion the following cases:
S v Gordon,
R v Matthews
Grotjohn
"Dr Death"

In 2001 the Dutch parliament passed an Act which declares doctor-assisted suicide in extreme cases lawful. The requirements are very strict:

1. the doctor must be satisfied that the patient's suffering is unbearable and
2. There is no prospect of improvement.

Distinguish between active and passive euthanasia

- Active euthanasia

The causing of death by a positive action is unlawful in principle. Consent to homicide is no defence.
We look to case law to determine if active euthanasia is allowed: - Include the following case discussions into your answer:
R v Dawidow,
S v De Bellocq,
S v Hartmann,
R v Makali, (causation theory)

The question is asked when can a physician shorten a patient's life?
Williams says that such 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. Due to the resistance of 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 dosage becomes lethal.

Where a patient is suffering and no treatment can avert death but his life may be slightly prolonged by the administering of drugs, the failure of the physician's conduct to administer the drugs will not be unlawful.
Where the physician does not administer the drug with is own hand but makes it available to the patient who then administers it to himself, is assisted suicide and is unlawful.

- Passive euthanasia

Do a complete discussion as in the question above but the only thing you do not need to do is define a living will.

NON-THERAPEUTIC PROCEDURES INVOLVING HEALTHY PERSONS

Three kinds of procedures are conceivable here:

1. prophylactic measures applied to a healthy person (vaccination)
2. procedures involving a healthy person with the object of eventually curing an ailing person (experiments)
3. operations performed without any curative purpose whatsoever (plastic surgery)

Prophylactic measures

The NHA governs blood and blood products. Section 55 provides that blood and blood products may not be taken from the body of a living person without written consent by the person. Section 56 provides such products may only be used for dental or medical purposes.

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 the removal of blood
- the person's name has been recorded by the person in charge of the
- relevant establishment in a register designated for such purpose
- 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.

A medical procedure performed upon the body of a healthy person to counter disease is recognized and praised, e.g. vaccination.

Curative purpose

A procedure may be lawful where it is undertaken upon the person of a healthy individual with a view to ultimately bringing about the restoration of another person who is ailing e.g. transplantation and blood transfusions.

1. Anatomical donations by living persons

The Human Tissue Act governs the removal of tissue, blood or gametes from the bodies of living persons for therapeutic and other uses. It 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 e.g. pace maker". "Gamete" is defined as "either of the two generative cells essential for human reproduction (sperm and ovum)".

Who can not donate what:
Mentally ill: tissue and organs that are not replaceable, e.g. kidney, gamete.
Minor: gamete (but may donate blood and skin).
Habitual criminal: gamete.

Tissue destined for transplantation may be removed only in a hospital or other authorized institution where the medical superintendent must provide a written authorization and may not carry out the transplantation himself.

The removal may be effected only with the consent of the donor (a minor – his parents consent). Where donors are fourteen or older and mentally competent, no parental consent is required before replaceable tissue and blood may be removed. Consent must be in writing except in the case of blood or tissue replaceable by natural processes.

The use of a gonad (testicle and ovary) for transplantation is illegal, unless the Minister's written consent has been obtained in advance – section 21.

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.

An operation for the removal of tissue will be unlawful if it is considered to be contrary to public policy (imperil the life and health of the donor). A court will decide this by carefully weighing the donor's interests against those of the recipient.

2. The removal of tissue from dead bodies

This is governed by the Human Tissue Act.

The acquisition of cadaver tissue is more problematical than tissue donation by live donors. The reason is that in civilized societies there is a deep-seated respect for the dead and compassion with the bereaved.

The "donor" must be deceased

The difference between an organ and a tissue:
An organ is an independent part of the body that performs a special function, e.g. hearts, lungs. Removal of an organ must take place immediately after the death and transplanted without delay.
A tissue, e.g. corneae or skin, need not be removed or transplanted immediately but may be stored for an indefinite period.

Before the test for death was the absence of heart activity. A problem was found in a heart transplant. In the first heart transplant operations, Professor Barnard and his team applied the following test: the absence of cardiac activity for five minutes as measured by electro-cardiagraph (ECG),

the absence of spontaneous respiratory movements and the absence of reflexes.

Today because of increased medical knowledge, modern methods of resuscitation and the demands of successful organ transplantation we have a new approach. Now medical science does not accept that there is one moment when a person dies, it sees death as a process.

It is generally accepted that for the continuance of life, the combined activity of the brain, heart and lungs is essential. Grave harm to the function any one of these organs has an immediate effect on the others. The most vulnerable is the brain. According to doctors, irreparable damage to the brain occurs after five minutes. Section 1 of the NHA states that brain death is accepted as sufficient.

The mere fact that a heart stops beating does not mean that its "owner" is dead. It can be restored by means of massage or electronic shock.

Damage to the brain might be such that the patient has reached "brain death". When this stage is reached there is one of two possibilities:

1. treatment ceases and "heart death" follows
2. treatment is continued and the heart may still function for sometime and the cease beating

At this stage the question is whether death is described as the cessation of both heart and brain activity, or whether "brain death" is sufficient. If "brain death" is sufficient physicians may disconnect their apparatus and remove organs from the body which are intended for transplantation. Removal of organs before the circulation of blood has ceased is an advantage. The NHA says brain death is sufficient.

The death of a person for the purposes of transplantation must be called by two doctors, one of whom must be practicing for at least 5 years and neither of them must be on the transplant team.

Whether or not death has ensued is a question of fact and in the event of a dispute, will be influenced by expert medical evidence.

Rules that apply today before the removal:
The Act provides that for the purpose of removal, the death must be established by two doctors, one who has been practicing for at least five years and neither may be a member of the transplantation team. Eye tissue is excluded from the provision. In respect of eye tissue an ordinary death certificate will suffice. (S v Williams).

To whom donations may be made – *section 3*

A donation of a whole body or parts there of may be made to a hospital, university or technikon or any other institution authorized by the Minister. If no donee (a type of institution) is nominated, the donation is of no effect.

However, it is not necessary for a donor to mention a specific institution by name. if he simply donates his body to "a hospital", the nearest hospital is deemed to be the donee or if the one nominated is not within easy reach, the nearest institution in the appropriate category is regarded as the donee. If a doctor, dentist or patient has been nominated and such a person is not within easy reach, the donation falls away.

If the donor has made conflicting donations, effect is given to the donation made last. However, if the donor had first donated is whole body to one donee and thereafter donated specific tissue to another, the first donation becomes effective.

Purposes of donations

A dead human body or specific tissue may be donated to an institution, doctor or dentist for the purpose of medical or dental training, research or the advancement of medicine. If a donee is a private individual it may be donated for therapy.

Consent

Consent is a prerequisite, except where removal takes place in the course of medico-legal autopsies. Consent may be given in one of the following ways:

1. by the deceased prior to his death in a will or statement. A relative of the donor cannot revoke a donation made by the deceased.
2. by the spouse, major child, parent, guardian or major brother or sister of the deceased after his death. Such consent can be given only if the deceased has not forbidden it prior to his death.
3. if none of the persons mentioned can be traced, the Director-general. There are two conditions:
    a. the deceased must not have given a contrary instruction
    b. the Director-General must be satisfied that all reasonable steps have been taken to trace the family members.

The question arises whether the official concerned may make such a donation if the identity of the deceased is unknown. This must be answered in the negative.

Official authorisation

For lawful removal of tissue from a dead body, official authorization is necessary. This is obtained upon request from anyone of the following:

1. magistrate in whose district the deceased died
2. medical practitioner in charge of the hospital or institution in which the deceased died, or of a mortuary where his body is kept.
3. any medical practitioner employed at such place

The authorization must be in writing on the prescribed form. No official authorization is necessary in the case of the removal of eye tissue.

The removal of tissue must be under medical supervision only

Gonads excluded

Prohibited in absolute terms.

Body not required for post mortem examination

Official authorization 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. These requirements are:

1. Section 3 of the Inquests Act – a post mortem where the deceased died from something other than natural causes.
2. Section 46 – post mortem to establish the possible presence of an infectious disease.
3. Section 15 – post mortem where the deceased is a still born child but where this is doubted or where the deceased was not treated by a medical practitioner during his last illness or where a medical practitioner was unable to issue a death certificate.
4. Section 34 of the Occupational Diseases in Mines and Works Act – post mortem of a former mine or industrial worker.

An exception is made for the removal of any specified tissue which would not affect the outcome of the examination, the district surgeon may consent to such removal. The rationale of this exception is that the bodies of healthy persons who died as a result of a criminal attack or accidental causes, are an excellent potential for transplanting.

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 afterwards.

Special provision is therefore made in the Act for the granting of official authorization for the removal of any specific tissue in medico-legal post mortem cases, if the doctor who is to conduct the examination certifies that:

1. 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

However this does not dispose of the consent requirements. The tissue must have been donated by the deceased, a relative or the Director-General.

b. Removal of tissue during post mortem examination

Special provision has been made for the removal of tissue from a dead body on which a district surgeon performs a post mortem under the Inquests Act. No such removal may be carried out if the medical practitioner involved (S9).

1. is not satisfied that the removal of tissue will in no way affect the outcome of the post mortem.
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.

Any person who objects to routine removal of tissue from his body in the event of an unnatural death may "veto" such removal during his lifetime.

The categories of tissue or organs which may be removed include kidneys, bone, tissue, tendon, cartilage, skin, heart valve, eyes, bone, dura mater, liver, aorta, heart, auricle.

c. Removal of tissues from bodies of deceased destitutes (can't trace them, find the family etc .)

Section 1 and 12 of the Human Tissue Act.
A body surrendered to an institution in terms of a formal order issued by the inspector of anatomy may be used for any of the statutory purposes such as medical training, research, transplantation.

Provisions designed to facilitate tissue acquisition

The Act contains a number of provisions are designed to facilitate the donation and acquisition of human tissue. The authorizing 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.

Time limit for removal of tissue

Except in the case of the entire body being donated, the donee of tissue has 24 hours following the death of the donor within which he may remove the tissue donated. After 24 hours have elapsed, the body may be claimed by the persons entitled thereto.

General considerations relating to both deceased and living donors

Rights concerning donated tissue

The person acquiring the tissue is vested with exclusive rights over such body or tissue, subject to the prohibition of sale.

Sale of tissue prohibited

No person or body except an authorized institution may receive payment in respect of the import, acquisition or supply of tissues or gametes, blood or blood products, in respect of which only prescribed institutions are exempted.

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 is entitled to a refund.

Genetic manipulation

This is prohibited. (S39A NHA)

Secrecy

The Act prohibits the publication of the identity of the donor of the body or tissue, unless consent, in writing, is given by the deceased, living donor, relatives or district surgeon who donated the tissue. If the recipient has died, consent may be given by a spouse, major child, parent or a major brother or sister of the recipient. The unlawful disclosure of identity constitutes a punishable offence.

Exclusion of civil and criminal liability

The Act exempts from civil and criminal liability a doctor who, 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.

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 was to be signed by the Director-General of Health.

Offences

Offences are punishable by a fine of R2000 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 not permitted by the Act.
2. using a gonad in the body of a living person contrary to the provisions of Act
3. removing, using or transplanting tissue by a person who is not a medical practitioner or dentist
4. disclosing of the identity of a donor or recipient of tissue, not 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

Diagnostic ("hospital") post mortem examinations

Section 8 states a post mortem of a body may be conducted before burial, if the deceased consented thereto or it is necessary to determine more precisely the cause of death or for a specific purpose (die from a rare disease). Consent by the deceased before his death is not an absolute requirement. All that must be established is that the autopsy is necessary. The Act contains no indication that relatives have to be consulted.

QUESTIONS

Write notes on anatomical donations between living people

Or

Write notes on the lawfulness of the donation of tissue for therapeutic or scientific purposes by a living minor, to be removed from the body while he is still alive

The Human Tissue Act governs the removal of tissue, blood or gametes from the bodies of living persons for therapeutic and other uses. It 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 e.g. pace maker". "Gamete" is defined as "either of the two generative cells essential for human reproduction (sperm and ovum)".

Who cannot donate what:
Mentally ill: tissue and organs that are not replaceable, e.g. kidney, gamete.
Minor: gamete (but may donate blood and skin).
Habitual criminal: gamete.

Tissue destined for transplantation may be removed only in a hospital or other authorized institution where the medical superintendent must provide a written authorization and may not carry out the transplantation himself.

The removal may be effected only with the consent of the donor (a minor – his parent's consent). Where donors are fourteen or older and mentally competent, no parental consent is required before replaceable tissue and blood may be removed. Consent must be in writing except in the case of blood or tissue replaceable by natural processes.

The use of a gonad (testicle and ovary) for transplantation is illegal, unless the Minister's written consent has been obtained in advance.

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.

An operation for the removal of tissue will be unlawful if it is considered to be contrary to public policy (imperil the life and health of the donor). A court will decide this by carefully weighing the donor's interests against those of the recipient.

Discuss the removal of tissue by a doctor in the course of a postmortem for transplantation

Or

Write notes on a hospital post mortem examination

Removal of tissue during post mortem examination

Special provision has been made for the removal of tissue from a dead body on which a district surgeon performs a post mortem under the Inquests Act. No such removal may be carried out if the medical practitioner involved (S9).

1. Is not satisfied that the removal of tissue will in no way affect the outcome of the post mortem.
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.

Any person who objects to routine removal of tissue from his body in the event of an unnatural death may "veto" such removal during his lifetime.

The categories of tissue or organs which may be removed include kidneys, bone, tissue, tendon, cartilage, skin, heart valve, eyes, bone, dura mater, liver, aorta, heart, and auricle.

Write notes on the removal of organs from the body of a deceased person for the purposes of transplantation

This is governed by the Human Tissue Act.
The acquisition of cadaver tissue is more problematical than tissue donation by live donors. The reason is that in civilized societies there is a deep-seated respect for the dead and compassion with the bereaved.
Before the test for death was the absence of heart activity. A problem was found in a heart transplant. In the first heart transplant operations, Professor Barnard and his team applied the following test: the absence of cardiac activity for five minutes as measured be electro-cardiograph (ECG), the absence of spontaneous respiratory movements and the absence of reflexes.

Today because of increased medical knowledge, modern methods of resuscitation and the demands of successful organ transplantation we have a new approach. Now medical science does not accept that there is one moment when a person dies, it sees death as a process.

It is generally accepted that for the continuance of life, the combined activity of the brain, heart and lungs is essential. Grave harm to the function any one of these organs has an immediate effect on the others. The most vulnerable is the brain. According to doctors, irreparable damage to the brain occurs after five minutes.

The mere fact that a heart stops beating does not mean that its "owner" is dead. It can be restored by means of massage or electronic shock.

Damage to the brain might be such that the patient has reached "brain death". When this stage is reached there is one of two possibilities:

1. treatment ceases and "heart death" follows
2. treatment is continued and the heart may still function for sometime and the cease beating

At this stage the question is whether death is described as the cessation of both heart and brain activity, or whether "brain death" is sufficient. If "brain death" is sufficient physicians may disconnect their apparatus and remove organs from the body which are intended for transplantation. Removal of organs before the circulation of blood has ceased is an advantage.

It is suggested that brain death should legally be accepted as death because in a vegetative existence, the only reactions are a heart beat and a measure of blood circulation, which are dependant on the artificial lung and increasing doses of drugs (a living corpse).

Whether or not death has ensued is a question of fact and in the event of a dispute will be influenced by expert medical evidence.

Rules that apply today before the removal:
The Act provides that for the purpose of removal, the death must be established by two doctors, one who has been practicing for at least five years and neither may be a member of the transplantation team. Eye tissue is excluded from the provision. In respect of eye tissue an ordinary death certificate will suffice. (S v Williams).

Include the following into your answer:
To whom donations may be made
Purposes of donations
The consent requirement

LEGALLY RECOGNISED MEDICAL PROCEDURES

USELESS OPERATION

A useless and unnecessary operation which has no precedent in the medical world is undoubtedly unlawful.

COSMETIC OPERATION (PLASTIC SURGERY)

This operation with consent cannot be regarded as unlawful unless it constitutes a threat to the patient's life or health. Even cosmetic operations are justifiable where deemed necessary for the psychological benefit of the patient (therapeutic nature).

CASTRATION

Surgical or chemical castration causes a man to lose the functioning of his testicles.

Non-therapeutic castration can't be considered lawful. From the sixteenth to the nineteenth century castration played an important role in the European world of music to ensure a certain quality of voice for opera and church music.

The Swiss author Noll says that castration may be justifiable where it is the only means of preventing a sexual offender from committing further crimes, psychotherapy having failed in his case. Otherwise it should be treated as an aggravated assault.

In S v V, a 20 year old accused was sentenced to death on 5 counts of rape and 5 lesser sexual offences. He appealed and requested the court to authorize a brain operation to diminish his sexual urges.
The court refused to allow a leucotomy to be preformed on a sexual offender. The death penalty was set aside and a term of imprisonment imposed. When V was released he raped two woman, one he killed and the other shot and killed him.

Here the accused could also have argued for castration but it is said that it would probably not have been granted any way.

Castration will be permissible in the following situations:

1. a child is born with the sexual organs of both sexes (hermaphrodite). The child's parents may decide that the male organs been removed allowing the child to grow up as a female.
2. a transsexual who has the sexual organs of a male but psychologically orientated as a female, may wish to be surgically "converted" into a female.
3. there may be a sound medical reason for the castration (testicular cancer).

Surgical castration, the surgical removal of the testicles which is irreversible must be distinguished from "chemical castration", the administration of a drug which inhabits both sexual performance and desire. This is an anti-androgen, which blocks out the male testosterone with the effect of suppression of the sexual desire being reversible.

Although the courts are reluctant to authorize surgical castration they will authorize chemical castration. In 2003 a Durban magistrate, Sharon Marks, sentenced a convicted paedophile, school teacher and ex-scout master, Deon Foster, to chemical castration.

STERILISATION

In the past sterilization to prevent the birth of more children was frowned upon.

Today, section 12 guarantees the right to life, to make decisions concerning reproduction, which includes the right to be sterilized.

The Sterilization Act defines "sterilization" as "a surgical procedure performed for the purpose of making the person incapable of procreation but does not include the removal of any gonad."

Requirements

No person is prohibited from having sterilization performed on him or her if he or she is:

1. capable of consenting
2. 18 years or above

Such a person cannot be sterilized without their consent.

The Act leaves no doubt that an unmarried person of 18 or older may be sterilized.

Sterilization may not be performed on a person who is under the age of 18, except where failure to do so would jeopardize the person's life or seriously impair their physical life. Such a request must be made by the youth's parent, guardian, spouse or curator to the person in charge of the hospital, who must convene a panel consisting of a psychiatrist or medical practitioner, if they are unavailable a psychologist or social worker and a nurse.

A contravention of these provisions is an offence and punishable by a sentence of up to five years imprisonment.

Persons incapable of consenting or incompetent to consent due to severe mental disability

Sterilization may only be performed on the request of a parent, guardian, spouse or curator of the patient. A panel must be convened to consider all relevant information, including that the patient is at least 18 years of age and that there is no other safe and effective method of contraception except sterilization.

Incompetency to consent refers to the situation where the patient is mentally disabled to such an extent that he or she is incapable of:

1. making his or her own decision about contraception
2. developing mentally to a sufficient degree to make an informed judgment about contraception or sterilization
3. fulfilling the parental responsibility associated with giving birth

Consent

This means consent given freely and voluntarily without any inducement (section 4). The patient or other person giving the required consent must have been given a clear explanation of:

1. the proposed plan of the procedure and
2. the consequences, risks and the reversible or irreversible nature of the sterilization procedure (informed consent)

Such a person must have been informed that consent may be withdrawn any time before the treatment. Consent must be given by way of signing the consent form. Consent in terms of the act therefore implies a fully informed consent.

A married spouse can consent to sterilization independently.

Whose duty is it to inform the patient? It is advisable for the doctor performing the procedure to do it himself but may delegate his duty to a responsible person but the doctor will be legally accountable.

Sterilization of persons incapable of consenting due to severe mental disability may be performed only at a facility designated in writing for that purpose by a member of a provincial Executive Council for health.

ABORTION

There is a view, based on religious principles, that abortion amounts to the murder of an unborn and can never be justified. The opposing view is that a woman is autonomous as far as her own body is concerned and the embryo or foetus is part of her body with which she can freely do as she wishes.
Abortion is governed by the Choice of Termination of Pregnancy Act.

In Christian Lawyers Association of SA and Others v Minister of Health and Others, the plaintiff argued that abortion contravened section 11 – the right to life. The defendant alleged that if the constitution wished to protect the foetus it should have been included in section 28. by relying on section 11 would mean that a woman could not have an abortion even where the pregnancy threatened her life or was a result of rape or incest.

When pregnancy may be terminated

1. the first 12 weeks
2. from the 13th week up to and including the 20th week
3. after the 20th week

The first 12 weeks

There is no age limit and may be terminated upon request by either a medical practitioner, registered midwife or a registered nurse.

From 13 to 20 weeks

There are seven different indications for termination effected in this period:

1. if the continued pregnancy will pose a risk to the woman's physical health
2. if the continued pregnancy will pose a risk 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 resulted from rape
6. if the pregnancy resulted from incest
7. if the pregnancy will significantly affect the social or economic circumstances of the woman

A medical practitioner must, after consultation with the woman, have formed the opinion that one of the above requirements is present. Only a medical practitioner may carry out the termination.

After the 20th week

There are three different indications for a 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

A medical practitioner must, after consultation with another doctor or a midwife, have formed the opinion that one of the above requirements is present. Only a doctor may carry out the termination.

Place where a termination may take place

It can only take place at a facility which:

- gives access to nursing and medical staff
- gives access to an operating theatre
- has appropriate surgical equipment
- supplies drugs for intravenous injection
- has emergency resuscitation equipment
- give access for appropriate transport to arrive in the case of an emergency
- has facilities and equipment for clinical observation
- has appropriate infection control measures
- gives access to safe waste disposal
- has telephonic means of communication
- has been approved by notice in the Government Gazette

For a termination within the first 12 weeks, a facility that complies with the above requirements may terminate a pregnancy without the consent of a Member of the Executive Council as granted in a Government Gazette.

Counselling and informing woman

There is a duty on the state to promote the provision of non-mandatory and non-directive counseling, before and after the termination of any pregnancy.

The counseling should provide sufficient information to the woman to assist her in making an informed decision. The woman should be advised of any alternative option, the procedure, the risks involved as well as contraceptive advice for the future.

In Unisa's 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.

Consent requirements

Termination can only take place with informed consent. Even a pregnant minor's consent is sufficient but a duty is imposed to first advise her to consult her parents, guardian, family members or friends but such procedure may not be denied.

In Christian Lawyers Association, the plaintiff sought an order declaring the defendant of no man in the act unconstitutional on the ground that a girl under 18 years is incapable on her own, without her parent's consent to take an informed decision on whether or not to terminate a pregnancy which serves her best interest. The court upheld the constitutionality.

The consent of the pregnant woman is not required in the case of a severely mentally disabled woman or where the woman is in a continued state of unconsciousness. Here consent of a representative is required. An additional requirement is that two doctors, or a doctor and a midwife, must have consented to the termination.

A woman with a disability may not be denied termination if a representative person refuses to give consent.

Sometimes consent isn't required in these circumstances:

- Up to and including 20th week, the pregnancy may be terminated without the consent of the woman's spouse or guardian, if two medical practitioners or a medical practitioner and a registered midwife are of the opinion that:
    a) Continued pregnancy is a risk to the woman's physical or mental health
    b) There is a substantial risk that the foetus, will suffer physical or mental abnormality

- After the 20th week can be terminated if
    a) Endanger the woman's life'
    b) Result in sever malformation of the child
    c) Pose a risk of injury to the foetus

With spouses a woman does not need her husband's consent.

Records of terminations must be kept and forwarded to the provincial health department but in doing this, the woman's identity must be omitted.

Criminal abortion

This is punishable by 10 years imprisonment.

Section 10 makes it a criminal offence to prevent the lawful termination of a pregnancy or to obstruct access to a facility for the termination, such preventing or obstructing may attract a penalty or a fine or imprisonment for

up to 10 years. This requires a positive action for liability and not a mere omission.
Section 10 doesn't exactly criminalize lack of informed consent or the refusal to perform a lawful termination.

It is a criminal abortion if it is performed by someone other than the prescribed person – please note this does not include the lack of a consulting person. It is further a criminal abortion if the abortion is performed at an incorrect facility but it is not per se a criminal offence if one of the grounds for an abortion are lacking.

Powers of the court to interfere

In G v Superintendent, 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. Here a mother of a 14 year old girl, who had been raped, applied for an order retaining an abortion being performed.

"PREGNANCY CLAIMS" AND ONES RIGHT OF REPRODUCTION

Terms:

1. **"Wrongful pregnancy" or "wrongful conception"**: a healthy, but unwanted, child is born, following negligent contraceptive advice, sterilization or abortion, and the parents claim damages.
2. **"Wrongful birth":** where a claim is brought by the parents of a handicapped or disabled child.
3. **"Wrongful life":** where a claim is brought by or on behalf of the handicapped or disabled child himself.

Conduct which may lead to claim 1:
- Failure to perform an agreed sterilization
- Failure to perform a sterilization properly
- Misrepresentation that a sterilization was performed
- False assurance that the patient is infertile

Conduct which may lead to claim 2:
- Failure to fulfill an agreement to end a pregnancy
- Failure to successfully perform an agreement to end a pregnancy
- Failure to diagnose a serious defect or disability in a foetus
- Failure to inform the parents of an unborn foetus about a defect that has previously been diagnosed
- Misrepresentation that a foetus is healthy and normal
- Misrepresentation that an abnormal foetus has been aborted

WRONGFUL PREGNANCY CLAIMS

(Failed Sterilizations / Abortions / Sterilizations not performed)

In the USA, the courts initially held that a doctor will not be held liable for negligence in the performance of sterilization operations which resulted in the birth of an unwanted, normal child because "to allow damages for the normal birth of a normal child is foreign to the universal public sentiment of the people".

Later things changed and doctors were held liable in some cases of this nature if negligence could be proven. Here the doctor had to pay damages in the form of medical expenses for the birth of the child. In exceptional cases the doctor was held liable for maintenance of the child.

There have been several cases in England:

In Thake and Another v Maurice, a married man had a vasectomy and then a sixth child was born. The plaintiff instituted an action for damages based on negligence on the grounds of the practitioner's failure to comply with the contractual agreement and to exercise delictual duty to take care (failure to warn them that the husband could again become fertile). The court held they were entitled to damages for parental stress, pain and suffering, as well as the reasonable cost for rearing the unplanned child. (this would not be applied in SA)

In Eyre v Measday, a woman who had undergone sterilization gave birth to a child. She could not prove that the operation had been performed negligently and her claim was rejected.

The first decision on "wrongful conception" in South Africa was handed down in Behrmann and Another v Klugman. The plaintiffs instituted an action for damages for the birth of a normal child after Mr. B had had a vasectomy. The action was based on the alleged breach of contract and alternatively negligence. The doctor denied that he had breached the contract or had been negligent. The judge found in favour of the doctor.

In Edouard v Administrator of Natal, the verdict went in favour of the child's parents. Here the parents had agreed with a provincial hospital that a tubular ligation was to have been formed on the woman at the time of giving birth to her third child. The hospital staff failed to tie her fallopian tubes. The couple believed that the procedure had been performed. Four months later she fell pregnant, gave birth to a normal child and a tubal ligation was then performed.

A factor in this case was that the defendant had conceded that the woman had requested the procedure because she and her husband could not afford to support any more children.

The plaintiff averred that he was entitled to receive further compensation, namely:

1. general damages for the discomfort, pain and suffering, and the loss of amenities suffered by his wife (they were married in community and it affected their joint estate).
2. the cost of maintaining the child until she attains the age of 18

The defendant denied liability for further compensation and said that it would be contrary to public policy to allow the parents of a healthy, normal but unplanned child to recover the costs of the upbringing of the child where the parents refuse to give the child up for adoption.

The court held that damages in the form of maintenance for the child were recoverable because "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 said that there would be nothing inconsistent in the attitude of the persons 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 sterilization.

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.

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 but the court was not prepared to award general damages for the pain and suffering.

This claim was brought on a contractual basis and a delictual claim was not conjoined.

This case was taken on appeal (Administer of Natal v Edouard) and confirmed by a five-judge bench. They held that to sue for maintenance but to refuse to give up the child for adoption would not be against public policy because it is that burden and not the child that is unwanted.

The Appellant division dealt in 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 outweigh the financial burden brought on by the obligation to maintain the child. The judge state that the wrong done was not that the birth was unwanted but that it was such a burden that was unwanted. He further held that a normal birth doesn't always constitute a blessing as the child may become a drug addict, criminal etc.

In countering the argument that it would be inhuman for a child to later find out that his parents were awarded damages because his birth was a mistake, the court held that by the parents wanting to keep the child and not put him up for adoption shows that the child was not unwanted. The court thereby confirmed the decision of the court in favour of the child's father. An important qualification was added to the finding of this court, namely that this conclusion was intended to pertain only to a case where a sterilization was performed for socio-economic reasons.

This decision leaves little doubt that in South Africa liability will arise in

1. the "classical" situation of "wrongful conception" and
2. the situation of "wrongful birth"

Reference is made to an unusual South African case where a doctor was sought to be held liable on the basis that he made a misrepresentation relating to the sterilization of a woman (Raath and Another v Mukheiber). Here a married couple claimed damages, when after giving birth to a normal child the doctor told them that he had performed a sterilization operation on her and 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.

The court found that the Plaintiffs had not proven that the doctor had made a misrepresentation.

The plaintiffs' appeal to the full bench succeeded. The doctor appealed to the SCA, which upheld the decision of the full bench.

The court (full bench and SCA) held that the plaintiffs were entitled to recover damage and be compensated by the doctor for pure economic loss in respect of

1. confinement costs and
2. maintenance of the child until it becomes self supporting.

The court made this important statement:

> "in a delictual action of this nature, the claim for damages is not limited only to the situation where the request for sterilization was made for socio-economic reasons" (par 48)

WRONGFUL BIRTH CLAIMS

"Wrongful birth" as a cause of action was upheld in principle in Friedman v Glicksman.

The plaintiff instituted action after she had consulted the doctor, a gynaecologist, during her pregnancy to advise her on the risk of being pregnant with a disabled infant and stated that she wished to terminate the pregnancy if the situation were so. Mrs. F alleged that the doctor had carried out certain tests and advised her that there was no greater risk than the normal risk of having an abnormal child and that it was safe to proceed to full term. She later gave birth to a defective child, Alexandra. She accordingly brought two claims:

1. a claim in her personal capacity for the expenses of maintaining and rearing Alexandra as well as for future medical expenses and hospital treatment and other special expenses (wrongful birth)
2. a claim in her representative capacity on behalf of Alexandra for general damages as well as a claim for future loss of earning (wrongful life)

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.

The court held that the plaintiff was entitled to recover damages on the wrongful birth claim because this case concerns abortion and not sterilization.

The judge held that "wrongful pregnancy" and "wrongful birth" claims are not contrary to public policy and ruled in favour of the mother on this aspect.

In Sonny v Premier, Kwazulu-Natal (2010), the court again considered a claim based on wrongful birth.
In this case a pregnant woman was sent for a scan which showed to be inconclusive but did indicate a risk of Down syndrome. On her return to the hospital two weeks later she was wrongly informed that the scan indicated that everything was normal. Four weeks later she returned to the hospital for a second scan and umbilical cord fluid was drawn to test for Down syndrome. This test indicated that the baby was normal. On birth it was discovered that the baby was Down-syndrome.

Two claims were instituted:
1. Wrongful birth claim for damages resulting from the birth of a child with Down syndrome based on both breach of contract and delict.
2. A claim for damages as a sterilization was performed during the caesarean without her informed consent.

The Plaintiff's arguments:

Regarding the first claim, they alleged that the staff had been negligent in not conducting the tests earlier as the woman was a high risk (aged 37) and they owed her a higher degree of medical care.

Regarding the second claim the woman alleged that she signed the consent to sterilization under the false pretense that the child was normal.

The courts findings:

On the first claim it was stated that the doctor at the hospital had a duty to inform her that the tests were not conclusive and what the dangers were with regards to the inconclusiveness of the test. The court found that the doctor was negligent and that this negligence could be causally linked to the birth of the baby. On a delictual claim, there was no contributory negligence on the part of the mother. Contributory negligence could be considered in the contractual claim.

On the second claim the court was not convinced on the evidence that the staff acted unlawfully and therefore rejected the claim.

This case was taken on appeal to the SCA in 2011 (Premier, Kwazulu-Natal v Sonny). In their judgment, the SCA did not refer to the concept of wrongful birth or any authority on it but decided the case purely on the grounds of delictual liability. The court pointed out that the court a quo used the test for negligence as laid down in the case of Kruger v Coetzee:

1. A reasonable person in the position of the Defendant would foresee the possibility of his conduct injuring another or causing patrimonial loss
2. A reasonable person would take steps to guard against such occurrence and
3. The defendant failed to take such steps

The court stated that the doctor should have given the woman a written indication and clear and unambiguous instruction. Failure to do so incurs liability.

The appeal was dismissed.

WRONGFUL LIFE CLAIMS

The first South African decision on "wrongful life" was handed down in Friedman v Glicksman.

In this case the court found that wrongful life claims cannot succeed in South Africa. The court ruled against the claim brought on behalf of Alexandra for general damages as well as future loss of earnings.

In doing so, the court gave the following reasons:

1. It would be contrary to public policy for the court to hold that it would be better not to have an unquantifiable blessing of life rather than have such life marred.
2. Allowing such a claim would open the door for such a child to be able to sue its parents because they allowed the child to be born knowing the risks of such birth.
3. Granting damages would be against the measure of damage allowed for by the law of delict. The defendant is not responsible for the child's disabilities but he is being asked to compensate for them. There is no criteria in our law to ascertain the difference in value between non-existence and existence in a disabled state.

In Stewart v Botha (2008) the SCA rejected the appeal and confirmed the judgment of the court a quo.
This case deals with the birth of a child, Brian, who was born with numerous serious defects.

Two claims were instituted:

1. The mother brought a claim against the Defendants (a general practitioner and gynaecologist) for damages resulting from the birth for special education and past and future medical expenses. (wrongful birth)
2. The father brought a delictual claim on behalf of the child for compensation for the same harm (wrongful life)

He alleged that the Defendants had been negligent in that they failed to diagnose the defects and inform the Plaintiffs. Had they been informed, the Plaintiffs would have opted for a termination of pregnancy.

The Defendants noted an exception against the claim as it did not reveal a cause of action and that such a claim would be against public policy. The high court confirmed the exception and rejected the Plaintiffs claim.

On appeal the SCA recognized the claim for the harm flowing from the child's disability but distinguished between the parent's claim and the child's claim.
The court stated that an act which caused harm could amount to a claim for damages due to negligence if one could prove that such claim complied with all the elements of a delict.

The court found that the act which caused the damage was not a positive act but rather an omission and one can only be liable if it can be proved that they had a legal duty to act positively.

The court stated that the crux of this case was the question of whether it would have been better – from the child's perspective – not to have been born? However to choose no life as a disabled person violates the sanctity of human life.
The court stated that the question goes so deeply into 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 to not acknowledge such claim and the high court was correct in rejecting such claim.

QUESTIONS

Name the reasons for lawful termination of pregnancy

1. The first 12 weeks

There is no age limit and may be determined upon request by either a medical practitioner or registered midwife.

2. From 13 to 20 weeks

There are seven different indications for termination effected in this period:

1. If the continued pregnancy will pose a risk to the woman's physical health
2. If the continued pregnancy will pose a risk 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 resulted from rape
6. If the pregnancy resulted from incest
7. If the pregnancy will significantly affect the social or economic circumstances of the woman

A medical practitioner must, after consultation with the woman, have formed the opinion that one of the above requirements is present. Only a medical practitioner may carry out the termination.

3. After the 20th week

There are three different indications for a termination effected in this period:

1. where continued pregnancy will endanger the woman's life
2. where continued pregnancy will result in severe malformation of the foetus
3. where continued pregnancy will pose a risk of injury to the foetus

A medical practitioner must, after consultation with another doctor or a midwife, have formed the opinion that one of the above requirements is present. Only a doctor may carry out the termination.

Discuss the grounds on which sterilization of a person may take place, in the case of adults and minors

Persons capable of consenting
No person is prohibited from having sterilization performed on him or her if he or she is:

1. capable of consenting
2. 18 years or above

Such a person cannot be sterilized without their consent.

The Act leaves no doubt that an unmarried person of 18 or older may be sterilized.

Sterilization may not be performed on a person who is under the age of 18, except where failure to do so would jeopardize the person's life or seriously impair their physical life. Such a request must be made by the youth's parent, guardian, spouse or curator to the person in charge of the hospital, who must convene a panel consisting of a psychiatrist or medical practitioner, if they are unavailable a psychologist or social worker and a nurse.

A contravention of these provisions is an offence and punishable by a sentence of up to five years imprisonment.

Consent
This means consent given freely and voluntarily without any inducement. The patient or other person giving the required consent must have been given a clear explanation of:

1. The proposed plan of the procedure and
2. the consequences, risks and the reversible or irreversible nature of the sterilization procedure (informed consent)

Such a person must have been informed that consent may be withdrawn any time before the treatment. Consent must be given by way of signing the consent form. Consent in terms of the act therefore implies a fully informed consent.

Whose duty is it to inform the patient? It is advisable for the doctor performing the procedure to do it himself but may delegate his duty to a responsible person but the doctor will be legally accountable.

The Act does not indicate that spouses consent is needed where the spouse is capable to consent and above the age of 18.

Discuss castration

Non-therapeutic castration can't be considered lawful. From the sixteenth to the nineteenth century castration played an important role in the European world of music to ensure a certain quality of voice for opera and church music.

The Swiss author Noll says that castration may be justifiable where it is the only means of preventing a sexual offender from committing further crimes, psychotherapy having failed in his case. Otherwise it should be treated as an aggravated assault.

In S v V, the court refused to allow a leucotomy to be preformed on a sexual offender. Here the accused could also have argued for castration but it is said that it would probably not have been granted any way.

When V was released he raped two women, one he killed and the other shot and killed him.

Castration will be permissible in the following situations:

1. A child is born with the sexual organs of both sexes (hermaphrodite). The child's parents may decide that the male organs been removed allowing the child to grow up as a female.
2. A transsexual who has the sexual organs of a male but psychologically orientated as a female, may wish to be surgically "converted" into a female.
3. There may be a sound medical reason for the castration (testicular cancer).

Castration, the surgical removal of the testicles must be distinguished from "chemical castration", the administration of a drug which inhabits both sexual performance and desire. This is an anti-androgen, which blocks out the male testosterone with the effect of suppression of the sexual desire being reversible.

Also discuss the doctor in Durban

With reference to case law and in context of contraception, sterilization and abortion distinguish and discuss legal liability for:

a. Wrongful pregnancy
b. Wrongful birth
c. Wrongful life

Start this question off by defining the three terms:

1. "Wrongful pregnancy" or "wrongful conception": a healthy child is born, following negligent contraceptive advice, sterilization or abortion, and the parents claim damages.
2. "Wrongful birth": where a claim is brought by the parents of an abnormal or disabled child.

3. "Wrongful life": where a claim is brought by or on behalf of the abnormal or disabled child himself.

Then discuss a wrongful pregnancy and the recognition of it in our law:
The question that arises is whether, in the case of alleged negligence in performing an abortion, resulting in the non-prevention of the birth of a normal child, there may be liability on the part of the doctor.

In your discussion refer to the case of Chalk v Fassler, and give a brief discussion on it.
You then need to discuss failed sterilization or sterilization not preformed: "pregnancy claims"
In the USA, the courts initially held that a doctor will not be held liable for negligence in the performance of sterilization operations which resulted in the birth of an unwanted, normal child because "to allow damages for the normal birth of a normal child is foreign to the universal public sentiment of the people".
Later things changed and doctors were held liable in some cases of this nature if negligence could be proven. Here the doctor had to pay damages in the form of medical expenses for the birth of the child. In exceptional cases the doctor was held liable for maintenance of the child.
Reference your English cases of: Thake and Another v Maurice, and
Eyre v Measday,
Then ensure you discuss the first decision on "wrongful conception" in South Africa - Behrmann and Another v Klugman.
And very NB is to discuss our leading authority on this aspect which came from the judgment in Edouard v Administrator of Natal. In discussing this case ensure you include the following:

- Facts
- Arguments raised
- First court's judgment
- Appeal court's ruling

Ensure you state that due to this case a claim for wrongful pregnancy / conception is recognized in our law.

Then discuss a wrongful birth and the recognition of it in our law:

"Wrongful birth" as a cause of action was upheld in principle in Friedman v Glicksman. – you can briefly include the facts of the case.

Reference is made to an unusual South African case where a doctor was sought to be held liable on the basis that he made a misrepresentation relating to the sterilization of a woman (Raath and Another v Mukheiber) – here you can further include the facts of the case for additional information.
Discuss Sonny.

State that such claims are recognized in SA

Then discuss a wrongful life and the recognition of it in our law:

"Wrongful life" – include the following:
A full discussion on the first South African decision on "wrongful life" in Friedman v Glicksman. Then the position where we are today with reference to the fact that SA does not recognise a claim for wrongful life. Discuss Stewart.

Discuss the provisions of the Sterilization Act – distinguish between the categories of patients and the legal requirements regarding consent

In the past sterilization to prevent the birth of more children was frowned upon.
Today, section 12 guarantees the right to life, to make decisions concerning reproduction, which includes the right to be sterilized.
The Sterilization Act defines "sterilization" as "a surgical procedure performed for the purpose of making the person incapable of procreation but does not include the removal of any gonad."

Make reference to the following:
Persons who are capable of consenting
Persons who are incapable of consenting or incompetent to consent due to severe mental disability
Form of consent required
Whose duty is it to inform the patient

Discuss the situation of sterilization of a mentally incompetent person

Sterilization may only be performed on the request of a parent, guardian, spouse or curator of the patient. A panel must be convened to consider all relevant information, including that the patient is at least 18 years of age and that there is no other safe and effective method of contraception except sterilization.

Incompetency to consent refers to the situation where the patient is mentally disabled to such an extent that he or she is incapable of:

1. Making his or her own decision about contraception
2. Developing mentally to a sufficient degree to make an informed judgment about contraception or sterilization
3. Fulfilling the parental responsibility associated with giving birth

"SEX-CHANGE"
(transsexualism or intersexuality)

This can occur for a "transsexual" – a person who has a normal male physique but feels emotionally like a woman or visa versa

According to doctors and psychologists, the transsexual is usually a deeply unhappy person whose condition gives rise to serious personal psychological problems and psychiatric treatment is of little assistance. Through surgery, the transsexual can be given at least the appearance of the sex with which he or she identifies him or herself (sex-change operation).

The success of a sex change operation depends on whether changes were made in respect of:

- chromosomes (male xx and female xy) – no change is possible,
- gonads (testicles and ovaries) – may be removed,
- genitalia (penis and vigina) – may be surgically removed,
- hormones – may be changed,
- psyche – psychological identification and
- societies attitude.

Certain doctors are of the opinion that the term "sex-change operation" is misleading because the sex of a person is determined at conception and is dictated by chromosomes. Therefore it is contended that a change of sex is physically impossible.

Other medical experts are of the opinion that sex is primarily a question of psychological orientation and not so much a psychological appearance.

In Unisa's opinion, consent to a "sex-change" by an unmarried person with the view of relieving grave psychoneurotic problems cannot inevitably be ruled as contra bonos mores. "Sex-change" by a married person would create grave legal problems because it affects the essence of marriage. Psychotherapeutic considerations could also be decisive in the interests of children or potential children. In the absence of such exceptional circumstances, it may be argued that consent to the operation on a married person could judge as conflicting with boni mores.

In the South African case of Jonker v Jonker, a divorce order was granted to a married female transsexual.

In W v W, the court also, in an undefended divorce action, considered the marital status of a married transsexual in a detailed judgment. The court refused to grant a decree of divorce and ordered absolution from the instance. The judge held that the plaintiff's evidence did not show that the operation which she had undergone had converted her into a female: she was accepted and looked like a woman and had the physical attributes of a woman. The judge held that a valid marriage requires the parties to be of the opposite sex.

It would appear that the legislature does recognize the factual possibility of a change of sex, but how the section would be interpreted if, in fact, future cases confirmed that a change of sex was not possible, lay beyond the scope of the present judgment.

Society has had a change of attitude towards sex-changes which is evident in the Alteration of Sex Description and Sex Status Act which allows a person to alter their sex description in the births register where they have undergone a sex-change surgery which resulted in gender reassignment.

An operation performed on a person who possesses the sex organs of both sexes (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.

The Constitutional Court judgment in *Minister of Home Affairs v Fourie (2006)* in which the constitutionality of same-sex unions was upheld, has greatly diminished the importance of the legal recognition of a sex change operation.

Same sex marriages have been recognized by the Civil Union Act.

GENETIC ENGINEERING

The term "genetics" comes from "gene". Your genes determine the characteristics you inherit from your parents, e.g. hair colour, eye colour, height, etc. = DNA
We only look at the ethical acceptability and legality of forms of genetic engineering.

Genome mapping and the Human Genome Project

A genome is a total of the DNA in a specific organism, including the gene.
The term "genome" refers to the complete set of hereditary factors of a person as contained in his chromosomes (total of the DNA in a specific organism).

Genome mapping entails "selling out" the specific sequence of the molecular "letters" forming the genetic code as fixed in DNA.

The primary aim of the Human Genome Project was to advance knowledge rather than to identify disease mutations. This projects purpose was to identify 20 000 – 25 000 genes, to store information on a data base, to make technology available to the private sector, etc.

The project led to the discovery of 1800 disease causing genes.
"Decoding" the genome – figuring out what each of the genes do – may however, take another 50 years.

Genetic counseling

Genetic testing and counseling of individual patients or potential parents of a baby with a severe genetic disorder, is practiced worldwide and accepted as beneficial.
With information obtained from the Human Genome Project we can now limit the number of pathogenic genes (genes which cause diseases) and carriers or those with genetic diseases can now make informed decisions on procreation.

Genetic Manipulation (Gene therapy)

This is the alteration of cells by genetic manipulation and use of cells to treat, prevent or cure an undesirable condition.

We are now able to manipulate hereditary material to the extent that with cloning it is possible to make identical copies of cells and individuals.

Corrective implants can be used to treat a wide range of diseases, including hereditary ones, by using the process of gene therapy (alteration of cells by genetic manipulation).

In 2000 there was a breakthrough in combating the generic disorder in the form of severe combined immunodeficiency in babies where the baby is given a normal copy of the defective gene responsible for the disease. Because bone marrow transplantation is a risky procedure it should be avoided.

There have been further developments which can benefit infertile woman in which a genetic make-up can be introduced into a ovum donated by a fertile woman, thereby allowing the child to have the infertile woman's genes.

Curing patients with serious ailments by means of gene therapy is deserving of praise and is lawful, provided no unacceptable and unlawful experimentation with persons of human embryos takes place.

Cloning

This is a technique whereby a genetically identical duplicate of an organism is produced through genetic manipulation.

A clone can be produced by means of somatic cell nuclear transfer which is the fusion of an egg cell with an ordinary somatic (body) cell by removing both nuclei and placing the egg cell nuclei into the somatic cell. The product of the fusion is persuaded to develop by 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 thus leaving the clone with the same chromosomal DNA as the person who provided the somatic cell.

Section 57 of the NHA recognizes that there is a difference between reproductive cloning and therapeutic cloning. The difference lies in the object behind the cloning. Reproductive cloning is aimed at the creation of a child whereas therapeutic cloning is aimed at using stem cells from a cloned embryo for a person suffering from a disease.

S57(1)(a) prohibits manipulation of any genetic material for the purposes of cloning a human being.

S57(1)(b) provides that no person may engage in any activity for the purpose of reproductive cloning of a human being.

The Act allows the Minister of Health with the authority to permit therapeutic cloning under prescribed conditions.

Contravention of this section is punishable by a fine or max 5 years imprisonment.

SCIENTIFIC EXPERIMENTATION

Section 12 (2)(a) enshrines the right of everyone not to be subjected to medical or scientific experiments without their informed consent.

Consent to suffer a minor injury to test something which may be of value to science is not contra bonos mores.

Reckless experimentation which is not directed at gaining scientific knowledge is illegal. This also applies to experiments which cause bodily harm.

Where the experiment takes place with the object of curing ailing persons, it should be experimented on a patient suffering from the disease. Where such a person is available for experimentation it would be hard to justify the experiment been done on a healthy person. If the experiment can be carried out on an animal, it is unjustifiable to carry it out on a human.

Section 11 and 71 of the NHA govern research and experimentation with human subjects. The provision for experimental or research purposes must be authorized beforehand by the user, the healthcare provider primarily responsible for the user, the head of the health establishment and the relevant health research ethic committee (s11).

Research can only be conducted on a living person in terms of section 71(1):

(a) In a prescribed manner
(b) And with written consent of the person after being informed of the objects and consequences involved.

Research on a minor for non-therapeutic purposes can only be conducted in terms of section 71(3)(a):

(i) In a manner and on conditions as prescribed
(ii) With the Minister of Health's consent
(iii) With the parent or guardian's consent and
(iv) The consent of the minor if they are capable of understanding

Section 73(b) states that a Minister may not consent where:

(i) The objects of the research can be achieved by conducting it upon an adult
(ii) The research is not likely to significantly improve the scientific understanding of the minors condition
(iii) The reasoning behind the parents' consent is contrary to public policy
(iv) The research poses a significant risk to the minor
(v) There is some risk to the health and well-being of the minor and the potential benefit does not significantly outweigh the risk

In South Africa, the South African Medical Research Council has the duty of exercising proper control over the utilization of human or animal material in experimentation relating to matters under its control.

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.
Stem cells have the ability to replicate and develop into different cell types. They are responsible for producing somatic cells with a limited life span.

A fertilized egg is totipotent because it has the ability to differentiate into every type of cell of the adult organism and produce an entire individual.

In the early stages of their development before an embryo is implanted into the uterine wall, it is called a blastocyst which contain embryonic stem cells in its inner mass. During the early stages of foetal development primordial germ cells are found in the foetus' gonads. These are powerful cells that can differentiate into almost every type of cell in the human body but have lost their ability to produce a human body.

Another category of stem cells is multipotent stem cells. These are stem cells that are to some extent already differentiated but still have the capacity to develop into a limited number of specialized cell types. it is thought that adult stem cells.

Stem cell research can enlighten us on the basic genetic mechanism underlying the process of development. Scientists believe that stem cells may be capable of curing diseases previously regarded as incurable, e.g. Parkinsons.

There has been some research done on adult cells which show that they can be genetically altered to resemble embryotic stem cells (harvested from embryos that were created for IVF purposes but not used).
Cells that have been manipulated in this way are known as induced pluripotent stem cells.
If an embryo was to be cloned using one of your somatic cells it would have the same genes as you do. If these cells were then implanted into your body, your immune system would not recognize them as foreign invaders. This would benefit gene therapy as it won't carry a risk of rejection.
The NHA vests the Minister with power to allow research on stem cells and zygotes which are not more than 14 days old.

EXPERIMENTATION ON EMBRYOS AND FOETUSES

A large number of unused and "unwanted" embryos are presently stored in freezers of fertility clinics. Many foetuses are also discarded in abortion clinics. 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 breakthrough that can benefit a countless number of ailing people.

The regulations on use of biological material contain provisions relating to research on embryos. Excess embryos from IVF may be used to produce embryonic stem cell lines provided written consent is obtained from the donor. Research on primordial cells obtained from aborted foetuses may be carried out on obtaining written informed consent. Any person who wishes to carry out research on stem cell therapy may do so after obtaining written informed consent from the donor.

The South African Medical Research Council (MRC) has laid down basic ethical guidelines on research relating to reproduction biology:

- The pre-embryo should be treated with the utmost respect
- 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.

The MRC recommends that research methods into AID should be limited to the essential, and that adequate consent should be obtained from all people involved in the donation. Artificial insemination procedures should be performed in full compliance with the regulations. Careful counseling and consent are required where donor sperm is used.

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 parents. On the other hand, gender selection may be beneficial in sex-linked genetic diseases and may be justified under exceptional circumstances.

ARTIFICIAL INSEMINATION

- AID (artificial insemination donor)
- AIH (artificial insemination husband)
- IVF (in vitro fertilization) – gamete intrafallopian transfer (eggs and sperm injected into a woman's fallopian tubes)

Statutory regulation

Artificial fertilization explicitly includes the following:

- Artificial insemination: placing a male gamete into a female reproductive system
- IVF: bring together of a male and female gamete outside of the human body with the view of placing it back into the female for the purposes of reproduction.
- Gamete intrafallopian transfer – the eggs are mixed with the sperm and injected into the woman's fallopian tubes
- Embryo intrafallopian transfer – transfer of an egg which has already been fertilized before being transferred into the fallopian tubes
- Intracytoplasmic sperm injection (ICSI) - This occurs when a single sperm is injected into an egg with a very fine glass needle. It results in fertilization, the zygote is transferred to the woman's uterus. this occurs when the sperm cannot penetrate the egg.

Artificial insemination is a lawful procedure, provided it is performed by a medical practitioner in accordance with the regulations promulgated by the Minister of Health in terms of the NHA.

Artificial insemination is defined as the introduction by other than natural means of a male gamete into internal reproductive organs of a female person for the purpose of human reproduction, including

1. the bringing together outside the human body of a male and a female gamete with the view to placing the product of a union of such gamete in the womb of a female person, or
2. the placing of a product of a union of a male and a female gamete which have been bought together outside the human body, in the womb of a female person for such purpose.

The artificial insemination regulations generally are not applicable to AIH but only to AID.

No person except a medical practitioner or somebody acting under his supervision can perform artificial insemination.

DONOR FILE

A doctor intending to obtain gametes for the purpose of artificial insemination, must open a personal donor file. Comprehensive written consent must be obtained from the donor for the following (section 55 of NHA):

- physical examination and interview
- taking of samples of gametes for the purpose of testing analyzing or processing
- certain personal details (except: name, id number, date of birth) being made available to the ultimate recipient
- certain personal details including his family history being made available to the doctor who will perform the operation
- certain confidential details regarding himself being made available to the Director-General of Health.
- The information relating to the Gamete donor must be relayed to a central data bank.

If the doctor has reasons to believe that at least six children have been artificially produced from the donor, the donor must be informed that no further donation may be made by him.

When donating the doctor must have undergone, no more than one year earlier, medical tests for sexually transmitted diseases as well as a sperm analysis or a gynaecological examination.

The donor may be reimbursed for any reasonable expenses incurred by him or her in order to effect the donation (section 60 NHA). It will amount to an offence should such a person receive any financial or other reward for such donation. This unlawful act is punishable by a fine or imprisonment not exceeding 5 years.

Where a donar and a recipient know each other, they must be psychologically evaluated and it must be confirmed in writing that they know each other.

A married donor needs to obtain their spouses consent in writing to donate but a married woman does not need her husband's consent to receive artificial insemination.

The donor file must be kept in safe custody.
The donor must be under 18, consent to a semen analysis.

A gamete is defined as either of the two generative cells essential for human reproduction (spermatozoon or ovum).

A gamete obtained from a specific donor may not be used for artificial insemination if the doctor involved knows or suspects that two or more pregnancies exist involving the same donor and possibility exists of two or more simultaneously pregnancies or that at least six artificially produced living children have been born as a result of the use of that donor's gametes.

A doctor who intends to artificially inseminate a recipient must open a personal recipient's file.

An artificial insemination may be performed on an unmarried or married woman. The consent of a married woman's husband is not a requirement but if the husband has not consented, the legal status of the child may be affected.

A doctor has a duty to inform them of all the implications of artificial insemination.

The doctor needs informed consent from the patient which includes consent to a physical examination and questioning, the withdrawal of the gamete, the artificial fertilization and the details being furnished to the central data bank.

The doctor handling the recipient must make sure that the recipient is physically, socially and mentally suited for artificial insemination. The wishes for both the recipient and donor must be respected regarding the population and religious group of the child to be procreated.

Where, on the account of the family history, the possibility exists that the recipient or donor is the carrier of a defect, examinations and tests must be carried out. If the tests are positive, genetic counseling must be given to the recipient couple and the donor's semen may not be used.

A transfer of more than 3 zygotes or embryos is prohibited.

A doctor who affected an artificial insemination must report the birth within 30 days to the doctor who handled the donation and must record such birth in the central data bank within 3 months of the birth. Should the child display a genetic defect, the doctor who performed the artificial insemination must attempt to determine if the cause thereof can be traced back to the donor or the recipient. If the effect can be traced back to the donor, the doctor who had handled the donation must be notified.

It is a criminal offence for a doctor to act other than in accordance with the regulations. It is punishable by a fine, 10 years imprison or both.

The legal position of the AID child

Any child born of a woman as a result of artificial insemination must for all purposes be regarded as the child of that woman in terms of the Children's Act.

Section 40(1)(a) states that if the fertilization done was not the husband's sperm then his consent is needed for the child to be a child born of married parents. Paragraph (b) contains the presumption in our law that both parents granted consent.

No rights, duties or obligation arise between the child born as a result of artificial insemination and the person whose gamete has been used.

The potential liability of the doctor

As far as the liability of the doctor is concerned, there are few aspects which are perhaps of a more academic nature. If the medical practitioner acts without the consent of the husband his conduct may likewise constitute iniuria as against the later.

Performing artificial insemination upon an unmarried girl under the age of 16 can possibly make the physician liable in terms of the Sexual Offences Act.

There is a distinct possibility that if a semen donor is HIV positive, the woman who is artificially fertilized and/or her child may be infected. Depending on the circumstances and the proof of negligence, the donor and/or the agency supplying the semen may be held liable for damages. Only in extremely exceptional circumstances would the doctor who performed the insemination incur liability.

If a doctor is negligent in using semen, so that a defective child is born, there is a possibility of liability on the basis of wrongful birth.

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 and he fails to fulfill his undertaking there may be liability arising from breach of contract. But proof of damage or loss may be difficult for the couple.

IN VETO FERTILIZATION (IVF)

Consent must be in writing – Section 55 of NHA

This was done for the first time with the so called "test-tube" baby in England and born in 1978. The woman, Mrs. Lesley Brown, could not fall pregnant because of an abnormal condition of her Fallopian tubes. By means of a needle, a ripe ovum was removed from her ovary and placed in a laboratory dish and sperm from her husband was added to it. The egg was fertilized and the developing embryo was placed in the woman's uterus.

In our opinion no ethical objection can be raised against such a procedure, and it is lawful, provided that the practitioner complies with the provisions of the Human Tissue Act.

SURROGACY AGREEMENTS

A Surrogate mother is a woman who bears a child on behalf of another woman, either from her own egg fertilized by the other woman's partner, or from the implantation in her womb of a fertilized egg from the other woman.

A surrogate motherhood agreement is an agreement between a surrogate mother and commissioning parents in which it is agreed that the surrogate mother will be artificially fertilized for the purposes of bearing the child for the commissioning parents.

In the past such an agreement was unenforceable as well as compensating the hostess for her "services" - This would seem to be contra bonos mores and therefore illegal.

Surrogacy agreements are now governed by The Children's Act 38 of 2005, Chapter 19, Section 292 – Section 303.
This Act makes provision for formal agreement between the surrogate mother and the 'commissioning parent', that is a person who enters into a surrogate motherhood agreement with a surrogate mother. The agreement must be confirmed by the High Court, and various requirements are set out for the validity of such an agreement.

Any child born of a surrogate mother in accordance with a valid agreement is for all purposes the child of the commissioning parent or parents from the moment of its birth. Conversely, a child born as a result of an invalid agreement will be deemed to be the child of the woman that gave birth to that child.

The provisions of the Act:

Section 292 states:

(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 the Republic;
   (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 the Republic;
   (d) the surrogate mother and her husband or partner, if any, are at the time of entering into the agreement domiciled in the Republic; 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.

Section 293 deals with the consent element of such an agreement. Its stipulates that consent of the husband, wife or partner has to be obtained in the following circumstance:

(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.

Section 294 states that no surrogate motherhood agreement is valid unless 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, is used.

Section 295 states that the 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 that 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.

Section 296 states:
(1) No artificial fertilization 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 fertilization 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 Act, 2003 (Act No. 61 of 2003).

Section 297 provides 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;
(e) 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
(f) 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

Termination of surrogate motherhood agreement is governed by **section 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.

Section 299 contains the effect of a 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.

Termination of pregnancy and surrogacy is governed by **section 300:**

(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, 1996 (Act No. 92 of 1996).
(2) For the purposes of the Choice on Termination of Pregnancy Act, 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.

Payments in respect of surrogacy prohibited in terms of **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 fertilization 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 or in the execution of such an agreement, is entitled to reasonable compensation therefor.

In terms of **section 302** no person may publish any facts that reveal the identity of a person born as a result of a surrogate motherhood agreement.

Section 303 lays down possible offences as:

(1) No person may artificially fertilize a woman in the execution of a surrogate motherhood agreement or render assistance in such artificial fertilization, unless that artificial fertilization 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.

An offence is punishable with a fine or imprisonment not exceeding 10 years or both.

Briefly, the Children's Act confirms the following with regards to surrogacy agreements:

- A surrogate agreement will be valid if it is in writing and is signed by all the parties. It must be entered into in the Republic and must be confirmed by the High Court (S292).
- Consent of the commissioning parents as well as the surrogate and her husband, wife or partner has to be obtained (S293).
- No surrogate agreement is valid unless the gametes of both commissioning parents or at least one of the commissioning parents is used (S294).

- The court may only confirm such agreement if the commissioning parents are unable to give birth and if they comply with the requirements for suitable parenthood. Further the agreement must be for altruistic reasons and the surrogate must have had at least one pregnancy and viable delivery and has a living child of her own. (S295)
- Artificial fertilization may only take place after the contract has been confirmed by the court and within 18 months thereof. (S296)
- The effect is that the child is for all purposes the child of the commissioning parent or parents from the moment of the birth and the surrogate mother or her husband, partner or relatives have no right of contact with the child unless provided for in the agreement. If the agreement is not valid the child is deemed to be the child of the woman that gave birth to that child. (S297)
- An agreement can terminate where the surrogate mother, who is a genetic parent cancels the agreement within 60 days of the birth, or the court can terminate the agreement (S298).
- The effect of termination and parental rights and responsibilities are contained in S299.
- A child can be aborted in a surrogacy if it is done in terms of the Choice on Termination of Pregnancy Act. The decision is that of the surrogate but she must inform the commissioning parents. (S300)
- Payments in respect of surrogacy prohibited but the surrogate can claim compensation for expenses that relate directly to the artificial fertilization and pregnancy, the birth of the child and the confirmation of the surrogate motherhood agreement. She can also claim loss of earnings and insurance to cover the surrogate mother for anything that may lead to death or disability. (S301)
- No person may publish any facts that reveal the identity of a person born as a result of a surrogate motherhood agreement. (S302)
- It is an offence for a person to artificially fertilize a woman without a court authorized agreement. (S303)
- An offence is punishable with a fine or imprisonment not exceeding 10 years or both.

Although this Act contains no regulations there is a practice directive.

Ex Parte Applications for the Confirmation of three Surrogate Motherhood Agreements (2011) brought to for the problems surrounding such applications.

The case laid down the following guidelines:

- Applications should not be brought to court on an urgent basis
- The courts confirmation on such agreements is not merely a rubber stamp
- The court has an obligation to ensure the child's best interest is of paramount importance and must take this responsibility as serious
- The success of the application is based on evidence before the court
- All expert reports must be compiled with care and must be reliable

The facts and evidence must refer to:

- Circumstances relevant to the parties
- Their financial means
- Emotional stability
- If they are able of being primary care-givers
- Permanency and reversibility of sterility of the commissioning parent
- Psychological screening
- Evaluation of the commissioning parents' home

On 27 September 2011 the North-Gauteng High court, in the case of WH and Others, approved and confirmed a surrogacy agreement between a homosexual couple, who had entered into a Civil Union the previous year and the mother and her life partner, who was pregnant with their child. The parties were introduced on an online site but no fee was paid.

In confirming the agreement the court emphasized the following:

- Where an agency is involved, the court must be fully aware of the agency to avoid commercial agreements
- Involvement of agencies has to be regulated and supervised
- Avoid different tests with regards to discriminating against same-sex couples
- The privacy rights of the commissioning parents must not be unnecessarily infringed.

QUESTIONS

Discuss the medical event referred to as artificial insemination

ARTIFICIAL INSEMINATION
There are two types:

- AID (artificial insemination donor)
- AIH (artificial insemination husband)

Statutory regulation
Artificial insemination is a lawful procedure, provided it is performed by a medical practitioner in accordance with the regulations promulgated by the Minister of Health in terms of the Human Tissue Act.

The artificial insemination regulations generally are not applicable to AIH but only to AID.

No person except a medical practitioner or somebody acting under his supervision can perform artificial insemination.

DONOR FILE
A doctor intending to obtain gametes for the purpose of artificial insemination must open a personal donor file. Comprehensive written consent must be obtained from the donor for the following:

- physical examination and interview
- taking of samples of gametes for the purpose of testing analyzing or processing
- certain personal details (except: name, id number, date of birth) being made available to the ultimate recipient
- certain personal details including his family history being made available to the doctor who will perform the operation
- Certain confidential details regarding himself being made available to the Director-General of Health.

If the doctor has reasons to believe that at least six children have been artificially produced from the donor, the donor must be informed that no further donation may be made by him.

When donating the doctor must have undergone, no more than one year earlier, medical tests for sexually transmitted diseases as well as a sperm analysis or a gynaecological examination.

A married donor needs to obtain their spouses consent in writing.

The donor file must be kept in safe custody.

The donor may be compensated for any reasonable expenses incurred by him in order to effect the donation. The Human Tissue Act, however, prohibits the sale of gametes.

A gamete obtained from a specific donor may not be used for artificial insemination if the doctor involved knows or suspects that two or more pregnancies exist involving the same donor and possibility exists of two or more simultaneously pregnancies or that at least five artificially produced living children have been born as a result of the use of that donor's gametes.

A doctor who intends to artificially inseminate a recipient must open a personal recipient's file.

An artificial insemination may be performed on an unmarried or married woman. The consent of a married woman's husband is not a requirement but if the husband has not consented, the legal status of the child may be affected.

A doctor has a duty to inform them of all the implications of artificial insemination.

The doctor handling the recipient must make sure that the recipient is physically, socially and mentally suited for artificial insemination. The wishes for both the recipient and donor must be respected regarding the population and religious group of the child to be procreated.

Where, on the account of the family history, the possibility exists that the recipient or donor is the carrier of a defect, examinations and tests must be carried out. If the tests are positive, genetic counseling must be given to the recipient couple and the donor's semen may not be used.

A doctor who affected an artificial insemination must report the birth within 30 days to the doctor who handled the donation. Should the child display a genetic defect, the doctor who performed the artificial insemination must attempt to determine if the cause thereof can be traced can be traced back to the donor or the recipient. If the effect can be traced back to the donor, the doctor who had handled the donation must be notified.

It is a criminal offence for a doctor to act other than in accordance with the regulations.

Discuss the validity of experimentation on humans and embryos

During 2001 the subject of stem-cell research on human embryos unleashed an international debate. Stem cells are the basic cells that form all the cells in the body. Some call them "magic seeds", for their ability to replicate indefinitely and develop into any kind of tissue. If taken from human embryos only a few weeks old, stem cells can be regarded as nature's "blank slates", capable of developing into any of nearly 220 cell types that make up the human body. Scientists believe they will lead to cures for diseases once regarded as untreatable or very serious conditions such as Parkinson's disease, Alzheimer's and diabetes.

A large number of unused and "unwanted" embryos are presently stored in freezers of fertility clinics. Many foetuses are also discarded in abortion clinics. There are millions of people all over the world that regard fertilization as the commencement of human life and the destruction of an embryo or foetus as contrary to their religious beliefs. But, 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 breakthrough that can benefit a countless number of ailing people.

The South African Medical Research Council (MRC) has laid down basic ethical guidelines on research relating to reproduction biology. The pre-embryo should be treated with the utmost respect and special care should be taken. The production of excess embryos for the sole purpose of research should be discouraged.

The MRC recommends that research methods into AID should be limited to the essential, and that adequate consent should be obtained from all people involved in the donation. Artificial insemination procedures should be performed in full compliance with the regulations. Careful counseling and consent are required where donor sperm is used.

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 parents. On the other hand, gender selection may be beneficial in sex-linked genetic diseases and may be justified under exceptional circumstances.

Discuss the element of cloning and the recognition of same in SA

This is a technique whereby a genetically identical duplicate of an organism is produced through genetic manipulation.

In 1997 the first mammal, Dolly the sheep, was cloned. In 2000 American scientists claimed that they had managed to clone a monkey. The cloning of human beings is also possible now by means of the "nuclear transfer" technique developed there. This requires the nucleus of a cell from an individual to be inserted into an unfertilized egg that has had its own nucleus removed. The resulting "reprogrammed" egg is given an electric shock to "persuade" it to develop into an embryo, a clone of the nucleus donor.

Section 57 of the NHA recognizes that there is a difference between reproductive cloning and therapeutic cloning. The difference lies in the object behind the cloning. Reproductive cloning is aimed at the creation of a child whereas therapeutic cloning is aimed at using stem cells from a cloned embryo for a person suffering from a disease.

S57(1)(b) provides that no person may engage in any activity for the purpose of reproductive cloning of a human being.

The Act allows the Minister of Health with the authority to permit therapeutic cloning under prescribed conditions.
Contravention of this section is punishable by a fine or max 5 years imprisonment.

Discuss the agreement known as surrogate motherhood and the current position of such agreements in SA.

A Surrogate mother is a woman who bears a child on behalf of another woman, either from her own egg fertilized by the other woman's partner, or from the implantation in her womb of a fertilized egg from the other woman.

In the past such an agreement was unenforceable as well as compensating the hostess for her "services" - This would seem to be contra bonos mores and therefore illegal.

Surrogacy agreements are now governed by The Children's Act 38 of 2005, Chapter 19, Section 292 – Section 303.
This Act makes provision for formal agreement between the surrogate mother and the 'commissioning parent', that is a person who enters into a surrogate motherhood agreement with a surrogate mother. The agreement must be confirmed by the High Court, and various requirements are set out for the validity of such an agreement.

The Children's Act confirms the following with regards to surrogacy agreements:

- A surrogate agreement will be valid if it is in writing and is signed by all the parties. It must be entered into in the Republic and must be confirmed by the High Court (S292).
- Consent of the commissioning parents as well as the surrogate and her husband, wife or partner has to be obtained (S293).
- No surrogate agreement is valid unless the gametes of both commissioning parents or at least one of the commissioning parents is used (S294).
- The court may only confirm such agreement if the commissioning parents are unable to give birth and if they comply with the requirements for suitable parenthood. Further the agreement must be for altruistic reasons and the surrogate must have had at least one pregnancy and viable delivery and has a living child of her own. (S295)
- Artificial fertilization may only take place after the contract has been confirmed by the court and within 18 months thereof. (S296)
- The effect is that the child is for all purposes the child of the commissioning parent or parents from the moment of the birth and the surrogate mother or her husband, partner or relatives have no right of contact with the child unless provided for in the agreement. If the agreement is not valid the child is deemed to be the child of the woman that gave birth to that child. (S297)

- An agreement can terminate where the surrogate mother, who is a genetic parent cancels the agreement within 60 days of the birth, or the court can terminate the agreement (S298).
- The effect of termination and parental rights and responsibilities are contained in S299.
- A child can be aborted in a surrogacy if it is done in terms of the Choice on Termination of Pregnancy Act. The decision is that of the surrogate but she must inform the commissioning parents. (S300)
- Payments in respect of surrogacy prohibited but the surrogate can claim compensation for expenses that relate directly to the artificial fertilization and pregnancy, the birth of the child and the confirmation of the surrogate motherhood agreement. She can also claim loss of earnings and insurance to cover the surrogate mother for anything that may lead to death or disability. (S301)
- No person may publish any facts that reveal the identity of a person born as a result of a surrogate motherhood agreement. (S302)
- It is an offence for a person to artificially fertilize a woman without a court authorized agreement. (S303)
- An offence is punishable with a fine or imprisonment not exceeding 10 years or both.

Although this Act contains no regulations there is a practice directive.

Ex Parte Applications for the Confirmation of three Surrogate Motherhood Agreements (2011) brought to for the problems surrounding such applications.

The case laid down the following guidelines:

- Applications should not be brought to court on an urgent basis
- The courts confirmation on such agreements is not merely a rubber stamp
- The court has an obligation to ensure the child's best interest is of paramount importance and must take this responsibility as serious
- The success of the application is based on evidence before the court
- All expert reports must be compiled with care and must be reliable

On 27 September 2011 the North-Gauteng High court, in the case of WH and Others, approved and confirmed a surrogacy agreement between a homosexual couple, who had entered into a Civil Union the previous year and the mother and her life partner, who was pregnant with their child. The parties were introduced on an online site but no fee was paid.

Write notes on the a sex change operation

"SEX-CHANGE" (transsexualism or intersexuality)
Occurs for a "transsexual" – a person who has a normal male physique but feels emotionally like a woman or visa versa

According to doctors and psychologists, the transsexual is usually a deeply unhappy person whose condition gives rise to serious personal psychological

problems and psychiatric treatment is of little assistance. Through surgery, the transsexual can be given at least the appearance of the sex with which he or she identifies him or herself (sex-change operation).

Certain doctors are of the opinion that the term "sex-change operation" is misleading because the sex of a person is determined at conception and is dictated by chromosomes. Therefore it is contended that a change of sex is physically impossible.

Other medical experts are of the opinion that sex is primarily a question of psychological orientation and not so much a psychological appearance.

In Unisa's opinion, consent to a "sex-change" by an unmarried person with the view of relieving grave psychoneurotic problems cannot inevitably be ruled as contra bonos mores. "Sex-change" by a married person would create grave legal problems because it affects the essence of marriage. Psychotherapeutic considerations could also be decisive in the interests of children or potential children. In the absence of such exceptional circumstances, it may be argued that consent to the operation on a married person could judge as conflicting with boni mores.

In your discussion include the following cases:
The South African cases of Jonker and W v W,

It would appear that the legislature does recognize the factual possibility of a change of sex, but how the section would be interpreted if, in fact, future cases confirmed that a change of sex was not possible, lay beyond the scope of the present judgment.

An operation performed on a person who possesses the sex organs of both sexes (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.

The Constitutional Court judgment in *Minister of Home Affairs v Fourie (2006)* in which the constitutionality of same-sex unions was upheld, has greatly diminished the importance of the legal recognition of a sex change operation.

Society has had a change of attitude towards sex-changes which is evident in the Alteration of Sex Description and Sex Status Act which allows a person to alter their sex description in the births register where they have undergone a sex-change surgery which resulted in gender reassignment.

DELICTUAL LIABILITY

INTENTIONAL CONDUCT (this test is objective)

The elements of a delict: act (omission or commission), wrongfulness (based on what is *contra boni mores*), fault (intention / negligence), causation and damages

There are actions available to a party in a delictual law suit:

- *Actio legis Aquiliae:* to claim compensation for patrimonial loss caused unlawfully and with fault.
- *Action for pain and suffering:* to claim compensation for non-patrimonial loss caused unlawfully and with fault including claims for: disfigurement, loss of amenities of life, pain, suffering, emotional shock and the loss of life expectancy.
- *Actio iniuriarum:* to claim compensation and satisfaction for non-patrimonial loss resulting intentionally and unlawfully from an infringement of a personality interest (physical integrity, privacy or dignity).

Negligence can occur in numerous instances, e.g.:

- failure to diagnose cancer in the early stages,
- failure to perform a proper examination,
- making use of inappropriate or defective instruments,
- leaving behind a puss swab,
- operate on the incorrect limb / organ,
- following the wrong procedure,
- cause a blood vessel to rupture,
- give an overdose of medicine,
- failure to refer the patient to a specialist,
- failure to record an allergy,

When a patient wants to institute action against the medical practitioner, the legal practitioner must ensure that they approach the matter after obtaining all of their necessary information.

The summons must contain all the relevant elements including the allegation that the Defendant was wrongful and negligent and that such conduct caused the harm.

If relying on delict it must be proved in court, on a balance of probabilities that all the elements have been complied with and that the damage (patrimonial and non-patrimonial) was caused by the wrongful act.

Medical treatment without consent

Mental 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, e.g. negotiorum gestio or statutory authority (Elliott).

In Burger v Administrateur, Kaap, the court stated that it is without doubt assault where a doctor operates on a patient without consent.

In Broude v McIntosh and Others, a doctor was sued by a patient for assault on the basis of alleged lack of informed consent. He was found to be guilty.

Unisa agrees with the submission made in obiter in Broude v McIntosh, that medical intervention without informed consent is assault and even if it was performed with due care and skill and does not result in any harm to the patient, the patient can still claim satisfaction. If an undisclosed risk does materialize and harms the patient, the patient can also claim based on negligence.

Invasion of privacy

From the doctor-patient relationship flows 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 nature as well as ethical.

An actionable invasion of a patient's privacy will result in the doctor's incurring liability under the *actio iniuriarum*. A doctor can escape liability only if he can prove a recognized ground of jurisdiction, e.g. consent or public interest.

At common law: a patient has a right to expect that the doctor doesn't disclose his ailments and treatment

S14 National Health Act: all information regarding a patient's health, treatment and stay at an institution is confidential unless:

1. Patient consents in writing
2. Court order allows for it
3. It amounts to a threat to public health

In Jansen van Vuuren and Another NNO v Kruger, the court stressed the legal nature of a doctor's duty to respect the confidentiality of his patient. The duty is not absolute but relative: a doctor be justified in disclosing his knowledge where his obligations to society are of greater weight than his obligations to the individual.

In this case, a homosexual man who was a well known resident of a small Transvaal town. He later moved to another town where he applied for life insurance and was required to have a medical. He went to a doctor in the new town and requested that Dr K keep it (his HIV status) confidential. The following day during a game of golf, Dr K told another doctor and dentist

about his condition. The doctor was sued for damages based on breach on doctor-patient relationship and infringement of privacy. The doctor pleaded that he had the defence of truth and public interest and that it was made on a privileged occasion.

The court a quo found that the disclosure was legally justified. On appeal the court drew attention to the fact that M had moved to another town and that the likelihood of him calling on either the dentist or Dr X was remote.

In determining whether Dr K had a social or moral duty to make the discosure and the other two doctor's had a reciprocal social and moral duty to receive it, the standard of the reasonable man applies. The court ruled there had been no such duty and the plaintiff was awarded damages for R5000.

As far as the public disclosure of private facts is concerned, the Hippocratic Oath, formulated by the father of medical science more than 2370 years ago, is still in use. It requires of the medical practitioner "to keep silence" about the information acquired in his professional capacity.

In C v Minister of Correctional Services the court had to deal with the issue of taking a blood sample in order to test for HIV without the relevant persons consent where C claimed damages for invasion of privacy after a blood sample was taken from him while in prison. The Correctional Services has guidelines to follow should they wish to take samples to test for HIV which includes counseling for the prisoner. The information given to C was in a group and not individually by a trained counsellor. The court found that no informed consent was given.
The Correctional Service alleged that the requirements to prove the *actio iniuriarum* were not proven as the employee drawing the sample was unaware of the wrongful act. Court held this case falls into a limited class of delict and fault was not required. C's right was infringed.

MEDICAL NEGLIGENCE
(foresee and prevent – regarding doctor's – std of care)

The doctor owes the patient a duty of care when performing an operation or giving treatment, to perform the procedure with such professional skill as to avoid injuring the patient. Failure to do so amounts to a delict or civil and the patient can claim damages.

The concept of negligence

Negligence refers to the blameworthy attitude or conduct of someone who has acted wrongfully this is found that on the account of carelessness, thoughtlessness or imprudence he failed to adhere to the standard of care legally required of him.

In the medical context the question arises whether failure by a doctor to inform a patient in advance of the possible risks involved in a particular medical procedure would constitute negligence even if the procedure as such was not performed in a negligent manner. In Richter, the court held that such failure could constitute negligence. This view was rejected in Castell v De Greeff, where a woman went in for an operation to remove lumps from her breasts and at the same time get implants. The implants caused an infection and resulted in her having to go through further surgery. The doctor was not found negligent with regard to not telling her about all the possible risks or complications but was negligent in that he did not take a puss swab in time so that she could receive the appropriate antibiotics. On appeal the court found that the patient had been adequately apprised of the inherent risks and the doctor's failure to quantify the degree of risk was not a material nondisclosure. The doctor had therefore complied with the criteria for informed consent laid down by the court.
The court however did find against the doctor on the issue of negligence. The plaintiff had proved that she developed post operative sepsis in her breasts, of which the doctor became aware, and that one of the organism causing the sepsis was resistant to the antibiotics. The doctor had been negligent in not timeously taking the pus swab and sending it for analysis. Damages in the amount of R7500 were awarded.

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.

The principle that reasonable skill and care are required and not a higher degree, was reaffirmed in Castell and in Van der Walt v De Beer. In the latter case, the court had to consider whether the Defendant (a specialist orthopaedic surgeon) had been negligent in not enquiring further on a radiologist report. After looking at the X-rays the doctor found no abnormalities and referred the patient to another specialist who specializes in injuries of the spine. The patient was referred to numerous doctors and

only a year later did a specialist find a tumor on his lung by looking at the original x-ray ordered by the doctor.
The defendant sued for alleged negligence.
The court stated that by the time the duty fell on the doctor to request a report from the radiologist, the patient could have already been in another doctor's care and no such duty thus existed. They held that the defendant was not negligent.

Can the locality where the doctor practices be a factor in assessing whether the doctor has complied with the required standard of care and skill? (the so-called "locality rule").

Locality rule:

In Van Wyk v Lewis, one of the judges made the following statement:

Objective test: one of the judges made the following statement: "You cannot expect the same care and skill 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, skill and judgment have been exercised." = in a situation like this you need to look at the objective circumstances in which the doctor operates (facilities, equipment and staff)

Subjective test: another judge took an opposite view and held that the same degree of care is required wherever the doctor may practice: the standard and uniformity of medical education in the Republic, modern means of communication by means 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, information distributed by pharmaceutical companies about medicine. In this situation you look at the subjective knowledge of the medical practitioner no matter where he is practicing to determine if he acted with the required degree of care and skill

South African writers generally supported the second view and drew attention to factors such as the following: the standard and uniformity of medical education in the Republic, modern means of communication by means 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, information distributed by pharmaceutical companies about medicine.

Objective and subjective test: Author Carstens argues, convincingly that a distinction should be drawn between the subjective abilities (skill, education and knowledge) and the objective circumstances. He argued that a lack of medical facilities and infrastructure should be considered in the assessment of his conduct.

Unisa supports the third view.

In Collins v Administrator, the court 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 this case a 16 week old child sustained permanent brain damage because a tracheotomy tube which supplied him with air, had been displaced. Due to staff shortage, a nurse was not near the child at the critical time. The court held that she had been negligent when she could not manage to replace the tube.

Types of negligence:

1. Negligence with regard to damage resulting from inadequate care, knowledge or skill applied when diagnosing or treating a patient. E.g. Castell v De Greef
2. Negligence with regard to damage resulting from failure to inform a patient how to behave to protect his health. E.g. Dube v Administrator, Transvaal.
3. Negligence with regard to damage resulting from a failure to inform he patient of a risk attached to an intervention.E.g. Richter v Estate Hamman.

The proof of negligence

The burden rests with the plaintiff to prove on a balance of probabilities. Because expert evidence is necessary, the plaintiff is usually confronted by a problem.

Can the plaintiff use *res ipsa loquitur* ("the thing speaks for itself").

We look at a single aspect, 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 by proof of the harmful event and that it was caused by the defendant, a factual presumption of negligence on the part of the defendant arises. The plaintiff will not be relieved 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 had been negligent. The principle is often invoked in negligence cases.

Here the plaintiff is not relieved of his onus but if the defendant does not give an acceptable explanation for what happened, the court can conclude negligence.

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, where following a surgical operation there was a failure to remove a surgical swab from the patient's body, causing painful

consequences. The court refused to find that the doctor was negligent on the basis of *res ipsa loquitur*.

The judge said: "the mere fact that a swab is left in the patient is not conclusive of negligence. It may have been better for the patient to leave the swab in rather than to waste time in exploring whether it is there or not.

In Pringle v Administrator Transvaal, the patient's vena cava was torn during an operation. She lost 2l's of blood and suffered brain damage as a result of it. After the operation her employment was terminated and the court found the doctor to be negligent.

In cross examination it was put to Dr S that he had "tugged" and pulled the vena cava. His answer was: "in retrospect I would say that I tugged to hard."

The judge said that in assessing the foreseeability of harm, the court must guard against "the insidious subconscious influence of *ex post facto* knowledge". "Negligence is not established by merely showing that the occurrence happened."

Here the doctor the doctor did not use the care and skill required and damages of approximately R90 000 were awarded to the plaintiff.

Author Van den Heever argues that the Constitutional principles support the extension of the doctrine to this type of case in South Africa.

Damage

Apportionment of damage is possible in medical law where more than one party is liable.

In the appeal judgment of Wright v Medi-Clinic Ltd, where negligence during birth left the baby brain damaged, the doctor had to pay 20% and the Medi-Clinic 80% of the damages.

D'Ambrosi v Bane the court dealt with the question of whether benefits paid by a medical aid for past and future expenses can be taken into account when determining the amount of damages. The court held that the benefits from the medical aid are not deductible for real and future medical expenses.

Proof of causal connection

In medical law factual causation often seems to be difficult to prove. This is because disease and disease processes can be very complicated and are often influenced by a host of variables.

The plaintiff in these cases almost invariably had some kind of pre-existing ailment which might have led to or contributed to the harmful result for which damages are sought. Risks are attached to most medical interventions and these risks might eventuate despite the medical practitioners best

efforts. In these type of cases it is important to note that the dreaded result could possibly have had other causes and thus breaks the causal connection.

In Pearce v Fine and Others, a man who had a problem with his prostate went into x-rays, was injected with contrast medium in order to take better pictures of the internal organs. The patient was a 54 year old male who had experienced problems with micturition. His doctor suspect inflammation of the prostate gland and referred him to the defendant doctor. The defendant doctor took the x-rays and both the doctor and the radiologist, G, left the room. On G's return she found the patient unconscious and quickly summoned the doctor and an emergency team. They attempted resuscitation but the patient later died. Expert evidence said that the cause of the death was the drop in blood pressure.
It was alleged that Dr L had been negligent because he left the patient before it was safe to do so. It was held that even if there had been negligence, it had not been established that the negligence was causally connected to the patient's death.
The patient could possibly have had cardiomyopathy which was evidenced by the fact that his heart was too heavy and evidence indicated that chances of survival if defibrillation had started immediately were very slim.

In Silver v Premier of the Gauteng Provincial Government, the patient went in for treatment of pancreatitis but by the time that he was discharged, his ability to walk properly had been permanently impaired. He sued the hospital for negligence because he got bedsores which became infected resulting in paralysis of the lower limbs. There were several risk factors present predisposing the patient for bedsores. When he went into hospital he was obese, diabetic, had to go for dialysed and had low blood pressure.

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 concluded that there had been no proof of a causal connection between any act or omission (bedsores) on the part of the hospital staff. Therefore the court held that the staff was not liable.

In Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another, a 17 year old underwent corrective nasal surgery after a sports injury. During the operation the patient went into cardiac arrest. The nurse had difficulty operating a defibrillator in an attempt to normalize the heart and the patient suffered serious and permanent brain damage. The court found that regardless of the circumstances the brain damage was unavoidable even if there had been no delay in starting the defibrillation and there was no negligence on the part of the anaesthetist.

QUESTIONS

Discuss the applicability of the res ipsa loquitur in regard to civil proceedings arising from alleged medical negligence

The ordinary rule concerning the burden of proof is that the burden rests with the plaintiff. Because expert evidence is necessary, the plaintiff is usually confronted by a problem.

We look at a single aspect, 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 by proof of the harmful event and that it was caused by the defendant, a factual presumption of negligence on the part of the defendant arises. The plaintiff will not be relieved 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 had been negligent. The principle is often invoked in negligence cases.

Our courts have displayed a marked unwillingness to apply the res ipsa loquitur doctrine – discuss the following cases:
Van Wyk v Lewis,
Pringle v Administrator Transvaal,

The proof of a causal connection between alleged medical negligence and the bodily harm suffered by the patient

Here you need to discuss proof of causal connection by referring to the following cases:
Pearce v Fine and Others
Silver v Premier of the Gauteng Provincial Government,
Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another

Discuss the invasion of the patients privacy

From the doctor-patient relationship flows 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 nature as well as ethical.

An actionable invasion of a patient's privacy will result in the doctor's incurring liability under the action iniuriarum. A doctor can escape liability only if he can prove a recognized ground of jurisdiction, e.g. consent or public interest.

Discuss the case of Jansen van Vuuren and Another NNO v Kruger, and the case of C v Correctional Service

As far as the public disclosure of private facts is concerned, the Hippocratic Oath, formulated by the father of medical science more than 2370 years ago, is still in use. It requires of the medical practitioner "to keep silence" about the information acquired in his professional capacity.

Discuss the standard of care expected from health professional's

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. This principle was reaffirmed in Buls and Another v Tsatsarolarkis – discuss the facts of this case briefly.

The principle that reasonable skill and care are required and not a higher degree was reaffirmed in Castell. In Roos v Sinclair, the court held that it is acceptable for a doctor to rely on nursing staff to assist with the handing out of medication to patients.

Can the locality where the doctor practices be a factor in assessing whether the doctor has complied with the required standard of care and skill? (The so-called "locality rule"). – discuss the locality rule with reference to Van Wyk v Lewis, and the different approaches.

Briefly reference Collins v Administrator.

WHO IS HELD LIABLE? – WHO DOES A PATIENT INSTITUTE ACTION AGAINST? – THE PRINCIPLE OF VICARIOUS LIABILITY

A person can be held delictually liable if he has ordered or authorized another to commit a wrongful act. Thus a doctor who has instructed his professional assistant to perform an unlawful operation cannot later use the excuse that he did not perform the operation with his own hands.

Relationship of employment

The general principle is that there must be a relationship of employment whereby one person stands in a position of authority over another in terms of which the former is legally capable of exercising control over the latter's actions.

Vicarious liability arises with the employer- employee relationship

1. There must be an employment relationship between the parties
2. The employee must have committed a delict
3. The delict must have been committed within the scope of his employment

In a relationship of employment one person stands in a position of authority over another in terms of which the former is legally capable of exercising control over the latter's actions.

A person is not vicariously liable, for the wrongful act of an independent contractor engaged by him. Such a contractor undertakes a specific job and in the execution thereof acts in accordance with his own judgment. In the medical context, the anaesthetist is an independent contractor. Provided that the surgeon, on reasonable grounds, believes that the anaesthetist is professionally competent to do the job, there is no question of liability on the part of the doctor. If the practitioner who refers the patient is not so convinced, he may be held liable on account of his own negligence.

One partner is vicariously liable for the wrongful act of another when such act falls within the scope of a partnership business (Lindsay v Stofberg NO and Mdletshe v Litye).

If a partner goes beyond the scope of the business then the other partner is not vicariously liable.

Examples of possible liability:

1. An independently practicing doctor who "hires" an operating theatre in a hospital. The hospital cannot be held liable for his negligence but can incur direct liability for its own negligence, e.g. defective theatre equipment.
2. The doctor or nurse who is a member of the staff of a hospital is a servant of the hospital authority , the hospital will be delictually liable.

It is possible for the state or a hospital to be sued:

In Esterhuizen v Administrator, Transvaal, the court held that a hospital authority was liable for the unskillful professional acts of a doctor employed by the hospital.

In Dube v Administrator, Transvaal, the hospital authority was held liable for negligence on the part of two plastermen and a doctor in the service of the hospital, in regard to the treatment of a patient's broken forearm, where the plaster had been applied too tightly and the patient's arm ha to be amputated.

In Premier of the Western Cape Province v Loots NO both the medical practitioner and the Premier, as the employer of the practitioner, were found liable for the negligent incident.

In Mtetwa v Minister of Health, the plaintiff had a valid cause of action where she had been treated in hospital for suspected tuberculosis and the treating physician was an employee of the hospital. It was alleged that the doctor had acted carelessly in prescribing a particular medicament for her and she suffered a series of unpleasant and harmful effects. The judge stated that 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.

What is a servant?

The courts have laid down a number of common-sense limitations on vicarious liability so as not to unduly broaden the concept of what a "servant" is.

In Hartl v Pretoria Hospital Committee, it was held that a doctor, who at the request of the hospital renders gratuitous services to the hospital, is not a servant thereof. So too, nurses or doctors who are employees of a hospital and who render assistance to an independent doctor performing an operation in the hospital theatre, were held not to be servants of the doctor.

Today, many public and private hospitals offer 24-hour emergency services. These services are offered on hospital premises by groups of privately practicing doctors who are not employees of the hospital. Should an issue of vicarious liability arise a court will probably rule that because the hospital authority has neither actual physical control over their actions, nor the right to control, the hospital cannot be held liable vicariously.

Independent contractor:
A person is not vicariously liable, for the wrongful act of an independent contractor engaged by him. Such a contractor undertakes a specific job and in the execution thereof acts in accordance with his own judgment. In the

medical context, the anaesthetist is an independent contractor. Provided that the surgeon, on reasonable grounds, believes that the anaesthetist is professionally competent to do the job, there is no question of liability on the part of the doctor. If the practitioner who refers the patient is not so convinced, he may be held liable on account of his own negligence.

Scope of employment

The emphasis has shifted from actual control (instructions and actual supervision) to the right of control. According to some authorities it is sufficient to establish that the servant is a member of the "organization" of the employer. The question must be asked whether the employer exercised control over the "where" and the "when", rather than the "how". In 1978 the court ruled that "the element of control has always been regarded as a factor of prime importance in determining the existence of a master and servant relationship" but the master would be liable if the servant could lawfully receive instructions from his superiors. (*Mhlongo*)

In South Africa it was held that the patient need not be a paying patient in order to have a right of recovery.

Direct hospital liability

A hospital authority incurring direct liability for its own negligence, i.e. not via the conduct of an employee. E.g. faulty equipment.

Whether there has been a breach of contract or negligence, will depend on all the circumstances and the evidence in a case. An assessment whether the care given fell short of what is reasonable, will involve consideration inter alia of the availability of human, physical and financial resources, the demands made of staff, the patient load, etc.

Employer's right to recovery

An employer is entitled to recover the amount of damages awarded to the plaintiff from the employee. (Stott)

Contingency fee

As medical negligence can be extremely costly to institute action on and due to the fact that cases are often lost as a lack of expert evidence, legal practitioners offer to take on such claims on a contingency fee basis. This means that the patient is not charged for the fee of the legal work during the matter but should the case be won, the parties agree that the practitioner is entitled to at least 25% of the income.

A DOCTOR / HOSPITAL PROTECTING THEMSELVES AGAINST NEGLIGENT CLAIMS BY PATIENTS - DISCLAIMER

Waiver by patient of future claim for possible negligence ("disclaimer")

The question asked is whether a doctor, hospital or other health-care provider protect themselves against liability for possible negligence in treating the patient or for some other form of malpractice, by getting the patient to sign a waiver of claims, indemnity form or so called "disclaimer" prior to the intervention?

Nowadays, many private hospitals have waiver clauses in their admission or consent forms which they require to be signed prior to treatment. These clauses may vary in their wording but they seek to protect the hospital against mishaps occurring in connection with nursing or handling the patient. There is no legislation in South Africa on this subject but it is doubtful whether the current legislation on harmful trade practices would be at all applicable in this regard.

It has been stated that these clauses are often drafted so broadly that they exclude claims in both contract and delict.

In SA a person has the right to access to the court (S34) and if a person signs such a clause they are waiving their right to sue and thereby infringing their constitutional right.

In this connection it should be noted that there is nothing in our law preventing a patient after a claim has arisen, to agree with the doctor or hospital to settle the claim or to abandon it in part or altogether.

In this country, waiver clauses or "owner's risk" clauses are fairly common in agreements pertaining, for example, to the transport or storage of goods.

In Durban Water Wonderland (Pty) Ltd v Botha and Another, a disclaimer protecting an amusement park against liability for injuries sustained by a mother and a child when flung from defective mechanical device, resembling a small jet aircraft mounted on a kind of merry-go-round, was likewise upheld as valid.

There has been no case of a doctor trying to protect himself against liability in this manner, but the question has been raised whether such a contract of waiver would be enforceable in our courts. Unisa's opinion has been that such contracts would probably be void because they would offend against public policy. A waiver by a patient safeguarding a doctor against liability for negligence would be tantamount to a patient "licensing" a doctor to practice bad medicine.

An indemnity clause that violates public interest will be null and void but one that excludes liability for personal injury is not necessarily invalid.

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.

However in Edouard v Administrator, Natal, there is an obiter dictum suggesting that a doctor could "contract out of liability" towards the parents of a child who was born to them after an unsuccessful sterilization. But there is no indication in the judgment that this would be possible where the doctor had been negligent. A judgment was handed down by in 1999 which was the first of its kind involving a hospital.

In the case of Burger v Medi-Clinic Ltd, a man went in for a haemorrhoid operation. The day after the operation he experienced nausea, faintness, dizziness, sweating, yawning and motionlessness. He needed to go to the bathroom when he lost consciousness and fell on his head fracturing his cheek bone. He suffered from pain, depression, concussion and permanent disfigurement. On entering the hospital he signed a consent form with an indemnity clause. He argued that the hospital was only indemnified for the actual operation and that the clause did not protect the hospital from gross negligence. The judge found that the consent form was not just for the operation but included admission to the clinic and after treatment care. The court found in favour of the hospital.

On appeal, the court ruled that a disclaimer of liability by a hospital is null and void. The court found that the actions complained about were not covered in the ambit of specific waiver clauses.

In Afrox Healthcare Bpk v Strydom, the patient alleged that treatment by the hospital had been negligent and the indemnity clause signed by him was contra bonos mores or alternatively that the clause should have been pointed out to him. The judge upheld these contentions and found in favour of the patient. The supreme court of appeal set aside the judgment and came to the conclusion that the indemnity clause was indeed legally enforceable. They said that there had been no evidence that the patient, when entering into the contract was in a weaker position. Although an indemnity clause would possibly not constitute a defence against gross negligence of hospital staff, no allegation of such a degree of negligence had been made by the patient in this case. The court ruled in favour of the hospital.

The court in Napier v Barkhuizen made reference to the Afrox case and confirmed that the inequality of bargaining power could be a factor in striking down a contract on public policy and constitutional grounds.
The court in this case however left open the possibility that an indemnity clause will not be upheld as a defence to gross negligence.
On appeal the court also rejected the argument that the indemnity clause was against the principle of good faith.

As the patient knew that he was signing the contract which included the waiver clause, he could not rely on the argument that he wasn't made aware of it when he signed without reading it. There was no duty on the staff to point out the indemnity clause to the patient.

The Consumer Protection Act 68 of 2008

Section 48 and 49 state that not only must indemnity clauses now be pointed out to the consumer but that the consumer be awarded the opportunity to consider these.

In terms of this Act and the definitions contained therein, a doctor is a service provider and a patient is in essence a consumer.

Section 48 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 agreement are so adverse to the consumer as to be inequitable
- The agreement was subject to a term or condition
  - Was unfair, unreasonable, unjust or unconscionable
  - The nature and the effect was not drawn to the attention of the consumer

Section 49 requires that a prospective consumer be informed of any conditions in a 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) further deals with any activity or facility 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,

Section 49(3) and (4) state that the provisions have to be brought to the attention of the consumer,
- written 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

This must be done before the consumer enters into the agreement, begins to engage in activity or be expected to pay – whichever occurs first.

Had these provisions been in force when the above matters (Afrox and Napier) went to court, then the outcome would surely have been different.

The CPA further answers the question laid down in Afrox as to whether a disclaimer can protect the medical practitioner against gross negligence. Section 51(1)(c) states:

> A supplier must not make a transaction or agreement subject to any term or condition if it purports 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;

This makes it clear that any term excluding gross negligence is void.

QUESTIONS

Discuss the liability of the hospital for the negligence of doctors and nurses working in the hospital (vicarious liability). Also discuss whether a disclaimer clause in the hospitals admission form would affect such liability

A person can be held delictually liable if he has ordered or authorized another to commit a wrongful act. Thus a doctor who has instructed his professional assistant to perform an unlawful operation cannot later use the excuse that he did not perform the operation with his own hands.

Relationship of employment
The general principle is that there must be a relationship of employment whereby one person stands in a position of authority over another in terms of which the former is legally capable of exercising control over the latter's actions.

A person is not vicariously liable, for the wrongful act of an independent contractor engaged by him. Such a contractor undertakes a specific job and in the execution thereof acts in accordance with his own judgment. In the medical context, the anesthetist is an independent contractor. Provided that the surgeon, on reasonable grounds, believes that the anesthetist is professionally competent to do the job, there is no question of liability on the part of the doctor. If the practitioner who refers the patient is not so convinced, he may be held liable on account of his own negligence.

An independently practicing doctor who "hires" an operating theatre in a hospital. The hospital cannot be held liable for his negligence but can incur direct liability for its own negligence, e.g. defective theatre equipment.
The doctor or nurse who is a member of the staff of a hospital is a servant of the hospital authority; the hospital will be delictually liable.

Briefly reference the following cases:
Esterhuizen v Administrator, Transvaal,
Dube v Administrator, Transvaal,
Mtetwa v Minister of Health,

What is a servant?
The courts have laid down a number of common-sense limitations on vicarious liability so as not to unduly broaden the concept of what a "servant" is. – Discuss Hartl v Pretoria Hospital Committee.

The emphasis has shifted from actual control (instructions and actual supervision) to the right of control. According to some authorities it is sufficient to establish that the servant is a member of the "organization" of the employer. The question must be asked whether the employer exercised control over the "where" and the "when", rather than the "how". In 1978 the court ruled that "the element of control has always been regarded as a factor of prime importance in determining the existence of a master and servant

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In this connection it should be noted that there is nothing in our law preventing a patient after a claim has arisen, to agree with the doctor or hospital to settle the claim or to abandon it in part or altogether.
In this country, waiver clauses or "owner's risk" clauses are fairly common in agreements pertaining, for example, to the transport or storage of goods.
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.
Discuss the following cases:
Edouard v Administrator, Natal,
Burger v Medi-Clinic Ltd,
Afrox Healthcare Bpk v Strydom.

CRIMINAL LIABILITY OF THE DOCTOR: MURDER AND CULPABLE HOMICIDE

INQUEST

The Inquest Act governs all matters with regards to inquests after the death of a person which was not due to natural causes. This is important for medical malpractice suits and to institute criminal proceedings.

The NHA that a death of a patient whilst undergoing a procedure of therapeutic, diagnostic or palliative nature is not deemed to be a death due to a natural cause (section 56).

If a death is caused during such a procedure then a post mortem must be performed before the doctor can issue a death certificate.

Section 2 of the Inquest Act provides that if a person has reason to believe that any other persons death was not due to natural causes must report his findings to the police.

A policeman who has reason to believe that any person has died from unnatural causes he has to investigate the circumstances of the death and report the death to the magistrate (section 3).

The police man must deliver the post mortem report to the public prosecutor in terms of section 4. Section 5 states that if no criminal proceedings are instituted then the Public Prosecutor shall submit the relevant information to the magistrate of the district concerned. If, on the information provided, the magistrate finds that the death was not due to natural causes he shall ensure an inquest is held by a judicial officer. In terms of section 17 if the judicial officer finds that the death was due to an offence on the part of someone then he must submit a record to the Director of Public Prosecutors.

WHAT IS A "HUMAN BEING"

The question in regard to both murder and culpable homicide is whether a human being has been killed. Section 239 of the Criminal Procedure Act contains a procedural provision as to whether the 'victim' is a human being:

> 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 was entirely separate from the body of its mother.

The breathing test

The method which was used to determine whether the child was breathing is to establish whether the lungs will float in water. This test is not 100% correct since it is acknowledged that the foetus, before birth, does in fact carry out positive respiratory movements, if subjected to a microscopic

examination, they reveal a close similarity with the lungs of a newly-born child that has breathed.

In S v Mshumpa a pregnant woman in her last trimester was shot in her womb and as a result the baby was stillborn. The question before the court was whether the accused could be charged with murder. The court stated that the principle of legality prevents finding the accused guilty of murder in this instance and it is not the courts, but rather the legislature's job to extend any definitions in law.

CAUSAL CONNECTION

In both crimes it is necessary to prove a causal connection between the act and the death of the victim. To prove causation we need to prove both the factual and legal tests.

DOCTOR IN GOOD FAITH, SUPPLIES MEDICINE TO A PATIENT AND HE DIES – *link to euthanasia & Dr assisted suicide*

The question asked is can the physician be convicted of murder or culpable homicide?

In answering, the test for causation must be applied, that is was the death a reasonable and probable consequence of the perpetrator's conduct and not the result of a new independent or intervening occurrence. If the medicine were made available in circumstances where the death of the receiver was not a likely consequence of such availability, then the existence of a causal connection will not be recognized by the courts.

One must consider various instances:

- If a practitioner makes a harmful substance available in a circumstance where death would be a likely outcome (assisted suicide)
- If the doctor encourages the patient to commit suicide
- If the practitioner knows that a substance is potentially highly dangerous but allows the patient to think it is harmless

All of which instances show that the existence of the causal link ought to be accepted and the liability of the practitioner will depend on the his /her fault.

THE DEGREE OF NEGLIGENCE

The general test to prove negligence is based on the reasonable person and is therefore an objective test.
It has been stated that the doctor must be grossly negligence.

Our law follows the principle *imperitia culpae adnumeratur* (ignorance or lack of skill is deemed to be negligence). This will be used where a doctor undertakes a certain activity that calls for expertise, experience or expert skill while not in possession of those. (S v Mkwetshana)

The test for negligence: A health care provider is negligent of a reasonable health care provider

- would have foreseen the possibility that his conduct could lead to the patient's death
- would have taken steps to safe guard against the patient's death and
- the health care provider failed to take these steps.

Carstens states that the degree of negligence will indeed play a role when considering the sentence.

CULPABLE HOMICIDE: EXAMPLES FROM CASE LAW

Negligence must be judged in the light of all the surrounding circumstances which include:

1. *Inherently dangerous substances, 'devices' or conditions*: greater care is required in such instances. A birth of a child can be seen as an inherently dangerous situation as well as a doctor prescribing certain substances. (R v Van Schoor and S v Mkwetshana)

2. *Doctrine of sudden emergency*: our law recognizes that the same level of care and skill can't be expected where a person has to act in an emergency as they don't have the opportunity to weigh up their available options. (S v Kramer)

3. *The patient suffers from some incapacity / defect / allergy*: once again greater care is required is such instances. This includes instances where one deals with aged patients.

4. *Statutory provision indicating negligence*: an example is the provision in the laws relating to donations that the competent person is responsible for ascertaining that certain tests for sexually transmitted diseases have been performed on a donor.

Overdose of medicine

In R v Van Schoor, a young assistant doctor who had little experience with a specific drug, was requested by another assistant doctor to help with treatment of some patients by administering the medicine, used ten times the recommended amount as he did not read the instruction and did not do any research. Two patients died and he was found guilty of culpable homicide.

In R v Van der Merwe, the doctor gave a prescription stating "40 tabs one tdspc (latin for three times a day)" but without indicating the dosage completely. The pharmacist was unable to reach him, so he consulted the British Pharmacopoeia and gave his own dosage as 40 tabs of 100mg strength. The doctor had initially intended to only prescribe 25mg. The woman took the medication but started to deteriorate and inspite of blood transfusions and vitamin k intake, she died. It was held that an experienced doctor should not be able to hide behind the pharmacist and he was found guilty of culpable homicide.

In S v Mkwetshana, a woman was suffering from asthma, there were complications in the hospital when she started convulsing, turning blue and foaming at the mouth and the young doctor administered 20cc of a recognized drug for the treatment of asthma. There was no improvement so he then decided it could be epilepsy and administered 20cc of another drug. The patient's condition improved and he left. 15 minutes later the patient died. Later expert evidence showed that only 5cc should have been used and even then diluted 1:10. The doctor was found guilty of culpable homicide. On appeal it was argued that the doctor did the best he could do in an emergency but this argument was rejected by the court.

Blood transfusion to the wrong patient

In S v Berman, there were two women in the same hospital with the same surname (Mrs HV and Mrs EV) and both patients of Dr N. They were in the same ward number but different sections. The ward number was indicated on the chart and not the section number. When the doctor enquired about the patient by surname he was directed to the wrong section, thereby causing the wrong woman (Mrs HV) to receive the blood transfusion. When Dr N arrived to follow up on the patient he noticed the error and immediately stopped the blood transfusion. The mix of bloods was however fatal and she died soon thereafter. Dr B, the doctor who performed the transfusion was convicted of culpable homicide as he should have enquired as to the name of the patient.

Radiology: excessive amount of contrast medium

In S v Bezuidenhout, a radiologist caused the death of a 6 week old baby because of the medium used for x-rays. 125ml was administered to the child and according to expert evidence it should only have been 30ml. The radiologist and radiographer were found guilty of culpable homicide. On appeal the radiographer's conviction was overturned but the doctor's was confirmed.

Incorrect procedure during anesthesia

In S v Kramer and Another, a relatively inexperienced anaesthetist, working with a surgeon to remove a ten-year-old's tonsils, failed to insert a tube correctly. The patient became cyanosed and the surgeon noticed this. He came to the conclusion that the tube was not in the trachea. The patient was ventilated and her colour improved. She suddenly became cyanosed again and attempts were made to stimulate her heart but she died in theatre.

In the magistrates court both the surgeon and the anaesthetist were convicted of culpable homicide on various grounds.

On appeal the court held that the surgeon had acted swiftly and reasonably and had taken all the reasonable measures to resuscitate the patient. They held that the anaesthetist had been negligent in failing to insert the tube correctly and to monitor the patient, by which the misplacement of the tube could have been discovered. It was further held that the surgeon could not be held liable for the negligence of the anaesthetist.

Failure of general practitioner to call in a specialist

In S v Nel, Dr N, a general practitioner, was attending to a woman giving birth to her third child. Immediately after the birth, Dr N experienced problems with the removal of the placenta. The patient bled profusely and died later that same evening from loss of blood and shock.

The patient's husband, H, was present and observed the incident. He testified that shortly after the birth, Dr N 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 followed between the two. By 19:00 Dr N left the maternity ward. Mr. H learnt from the matron that there was a specialist on the premises and told Dr N. He told H that he was "not a monkey" and that he would call in a specialist should there be a need for one.

Between 19:00 and 19:20 H was informed by Dr N that he had called in 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 done.

The anaesthetist immediately took the patient's blood pressure, commenced an infusion and administered anaesthesia. Only then did N at the request of the matron call in a specialist, Dr S, with the remark that "a second opinion would do no harm".

At 20:10, Dr S arrived and started attending to the patient. He removed the placenta tissue and began to suture the incision, which had remained unsutured up to that stage. Before he could complete this the patient died at 20:20.

Dr N was charged with culpable homicide.

On appeal to the High court the doctor contended the judgment by stating that the court could not prove beyond a reasonable doubt that the omission had led to the patients death. The court upheld the judgment but reduced the doctors sentence.
The SCA refused leave to appeal.

Failure by a doctor to care for a patient post-operatively

In S v Van Heerden, a patient went in for a hysterectomy and after the operation the staff noticed her blood pressure was extremely low and her pulse very high. They contacted the accused and gave the doctor the relevant information.
The doctor gave the nursing sister instructions over the phone on how to treat the patient. The accused failed to visit the patient immediately and she died later that afternoon from internal bleeding.
The court had to determine if the doctor was negligent in not going to see her immediately and whether she could have been saved had he seen her.
The court held that the moment the doctor was informed about the readings he had a legal duty to go and see her and was therefore negligent.
Expert evidence further revealed that the patient's life could have been saved had the doctor been present and acted immediately.
The court found the link between the negligence of the accused and the death and both the accused was found guilty of culpable homicide.

On appeal the court set both the conviction and the sentence aside as they found that the nursing sisters evidence was unreliable and that she probably did not give the doctor the full readings. The court accepted the doctors statement that had he been properly informed of the gravity of the situation that he would have immediately gone to her.

Doctors can also be convicted of:

- Assault
- Criminal defamation
- *Crimen iniuria*
- Fraud
- Perjury
- Contempt of court

QUESTIONS

Bob Smith goes to his local pharmacy with a prescription from his doctor, Dr Joe. The prescription only indicates the number of tablets but not the dosage. The pharmacist can't get hold of the doctor to ask about the dosage and therefore gives the strength he thinks is reasonable however evidence later reveals that the dosage was too high. The pharmacist forgets to advise Bob of the availability of a generic version of the medicine prescribed. A few days later Bob goes to Dr Joe with bleeding which seems to be worsening and Bob had become extremely weak. Dr Joe admits Bob into hospital for a blood transfusion. The doctor is at the same time attending to another patient, Billy Smith, who is in the same ward. The doctor performs the blood transfusion on the wrong patient. Both patients die as a result thereof.

Dr Joe is charged with culpable homicide. He is of the opinion that the pharmacist was negligent and is worried in respect of the incorrect blood transfusion and approached you for advice.

In R v Van der Merwe, the doctor gave a prescription without indicating the dosage the pharmacist was unable to reach him, so he gave his own dosage. The woman started to deteriorate and inspite of blood transfusions died. It was held that an experienced doctor should not be able to hide behind the pharmacist and he was found guilty of culpable homicide.
Therefore Dr Joe would be guilty and not the pharmacist.

In S v Berman, there were two women in the same hospital with the same surname. They were in the same ward number but different sections. The wrong section number was indicated on the chart causing the wrong woman to receive the blood transfusion. She died and the doctor was convicted of culpable homicide.
Therefore he could further be liable on the basis of culpable homicide for the death of Billy Smith.