

DEPARTMENT OF CRIMINAL AND PROCEDURAL LAW



ONLY STUDY GUIDE FOR LCR404U

ADV L C COETZEE
PROF S A STRAUSS

UNIVERSITY OF SOUTH AFRICA, PRETORIA

© 2001 University of South Africa

Revised edition 2008

All rights reserved

Printed and published by the
University of South Africa
Muckleneuk, Pretoria

LCR404U/1/2008–2010

98254049

3b2

CONTENTS

| <i>Study units</i> | <i>Page</i> |
|--|-------------|
| INTRODUCTION | v |
| 1 THE CONSTITUTION AND MEDICAL LAW | 1 |
| 1.1 Introduction | 1 |
| 1.2 The prohibition of unfair discrimination | 1 |
| 1.3 The right to life | 2 |
| 1.4 The right to freedom and security of the person | 3 |
| 1.5 The right to privacy | 3 |
| 1.6 The right to health care | 4 |
| 1.7 The rights of children | 6 |
| 1.8 The right to information | 6 |
| 1.9 The right to just administrative action | 6 |
| 1.10 The rights of prisoners | 6 |
| 2 THE SOUTH AFRICAN HEALTH-CARE SYSTEM | 9 |
| 2.1 Introduction | 9 |
| 2.2 Regulation of Medical, Dental, Nursing and Supplementary Health Service Professions | 10 |
| 2.3 Hospital and state medical services | 11 |
| 2.4 Public health | 13 |
| 3 REGULATION OF THE MEDICAL PROFESSION BY THE LAW | 16 |
| 3.1 Introduction | 16 |
| 3.2 The Health Professions Council of South Africa (HPCSA) | 17 |
| 3.3 Professional boards | 18 |
| 3.4 Registration of practitioners | 19 |
| 3.5 Compulsory community service | 20 |
| 3.6 Continuing education may be required | 20 |
| 3.7 Practice by unregistered persons prohibited | 20 |
| 3.8 Unprofessional conduct | 25 |
| 3.9 Disciplinary powers of professional boards | 26 |
| 3.10 Appeal against adverse disciplinary finding, and review | 27 |
| 3.11 Restrictions on impaired students or practitioners | 28 |
| 3.12 Practitioners' charges | 28 |
| 3.13 Various provisions relating to medicines prescribed for or supplied to patients | 28 |
| 3.14 Anaesthetic deaths | 30 |
| 3.15 Medical and health records | 31 |
| 3.16 Discharge reports | 31 |
| 3.17 Complaints by patients | 31 |

| | | |
|---|--|-----|
| | 3.18 Duties of patients to comply with rules | 32 |
| | 3.19 Rights of doctors and other health care personnel | 32 |
| 4 | CONTRACTUAL RELATIONS | 34 |
| | 4.1 The contract between doctor and patient | 34 |
| | 4.2 Mutual contractual relations between doctors | 38 |
| 5 | THE LEGAL BASIS OF MEDICAL INTERVENTION | 48 |
| | 5.1 Consent as ground of justification | 49 |
| | 5.2 The concept of consent | 58 |
| | 5.3 The doctor's duty to inform the patient | 70 |
| | 5.4 Doctor deviating from operation consented to | 76 |
| | 5.5 Medical intervention without consent in emergencies | 76 |
| 6 | LEGALLY RECOGNISED MEDICAL PROCEDURES | 81 |
| | 6.1 Introduction | 81 |
| | 6.2 Therapeutic procedures | 82 |
| | 6.3 Non-therapeutic procedures involving healthy persons | 91 |
| 7 | LEGALLY RECOGNISED MEDICAL PROCEDURES (Continued) | 118 |
| | 7.1 Introduction | 119 |
| | 7.2 Abortion | 119 |
| | 7.3 Scientific experimentation | 128 |
| | 7.4 Artificial insemination | 130 |
| | 7.5 Embryo transfer, <i>in vitro</i> fertilisation (IVF) and surrogate motherhood | 134 |
| | 7.6 "Sex change" (Transsexualism or Intersexuality) | 139 |
| | 7.7 Genetic engineering | 143 |
| 8 | CRIMINAL LIABILITY OF THE DOCTOR: MURDER AND CULPABLE HOMICIDE | 150 |
| | 8.1 Introduction | 150 |
| | 8.2 What is a "human being"? | 151 |
| | 8.3 Causal connection | 152 |
| | 8.4 Doctor in good faith supplies medicine to patient, who dies | 152 |
| | 8.5 Doctor supplies harmful substance to a suicidal patient | 153 |
| | 8.6 The degree of negligence | 155 |
| | 8.7 Culpable homicide: examples from case law | 156 |
| | 8.8 Other doctrines and offences | 163 |
| 9 | DELICTUAL LIABILITY | 165 |
| | 9.1 Introduction | 165 |
| | 9.2 Intentional conduct | 166 |
| | 9.3 Medical negligence | 170 |

INTRODUCTION

General

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

The nature of this module

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

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

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

Ius medicum or medical law, again, is that branch of the law which is concerned with the study of the legal provisions relating to the practice of medicine and of health-care professions in general.

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

In this module we concentrate on important aspects of medical law. Since it is not possible to cover the entire field due to its vast scope, we are compelled to work selectively. Medical law is an applied subject. We are not primarily interested in the theory of the subject, but rather in its positive legal application in the particular relationship between doctor and patient. However, this approach still does not prevent us from considering the possible future legal development (the so-called *lex ferenda*) in connection with specific aspects of medical law.

The law stated in this study guide is as it was on 1 March 2007.

We would like to point out that the bulk of the National Health Act 61 of 2003 came into effect on 2 May 2005. The parts of the Act that have **not** yet been proclaimed are:

Section 11 of chapter 2, dealing with health services for experimental or research purposes.

Sections 50 and 51 of chapter 7, which provide for the establishment of a forum for statutory councils and academic health complexes respectively.

Chapter 6 in its entirety, dealing with health establishments and, in particular also with the controversial “certificate of need” which doctors and other health-care providers will have to obtain from the Director-General of the Department of Health before establishing a practice or setting up a health facility such as a hospital.

Chapter 8 in its entirety, dealing with the use of blood, blood products, and human tissues and gametes.

Section 71 of chapter 9, dealing with research on or experimentation with human subjects.

Section 77 of chapter 10, dealing with the establishment of an inspectorate of health establishments.

Section 78 and 79 of chapter 10, dealing with the office of standards compliance and inspections by the office of standards compliance respectively.

Section 83 of chapter 10, dealing with environmental health investigations.

Section 93(1) of chapter 12, dealing with the repeal of certain sections of certain other relevant Acts.

Amendments to the contents of your study guide will be necessary once the provisions mentioned above take effect. We will inform you when the provisions have come into force.

It is necessary to bring another concept to your attention, namely forensic science. This term includes the entire discipline that aims at establishing and proving juridically relevant scientific facts in the courts. Forensic science thus includes the science of identifying persons (by means of fingerprints, vocal frequencies, and other physical characteristics), ballistics (identification of bullets), graphology, forensic psychiatry and, of course, forensic medicine. Forensic medicine is offered as a separate module by this University. Forensic psychiatry is also of great importance in our time; we touch on it in Criminal Law in connection with the defence of mental disorder.

The value of this module

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

Medical science did not evolve in a vacuum, and medicine cannot be practised

in a vacuum, figuratively speaking. The healing science is directed in principle to serve the interests of human beings, society in other words, and is practised in a world governed by religious beliefs, ethical codes and legal systems.

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

The evolution of medical science was a relatively slow process of trial and error until the late 19th century. Since approximately the middle of the 20th century its evolution has been increasingly rapid and nothing short of miraculous. By the beginning of the 21st century procedures which not so long ago were regarded as science fiction or were not even dreamt of, have become commonplace. In addition the range of highly effective forms of medication has expanded beyond all recognition.

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

On the positive side there have been spectacular advancements in respect of human genetics, for example. However, genetic engineering has raised ethical and legal problems to which we do not yet have final answers.

The purpose of this module is to enable you to gain a sound knowledge of the legal principles applying to medical science and health-care workers. Many of these principles are of direct practical use. In respect of some of the most modern innovations we are not yet able to give final answers to the concomitant ethical and legal issues, but we hope to make you at least aware of what the answer or possible answers might be. Above all we have set out to stimulate your interest so that you may think independently about these issues.

Format of the study guide

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

Format of a study unit

Each study unit is presented as follows:

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

Recommended books and articles in journals

Many books have been published all over the world on medical law or aspects thereof. The subject is “international” in the sense that court rulings in one country may be of persuasive value to courts of other countries. The views of legal authors may also be of persuasive value to courts in other countries.

The most recent book published in South Africa which in part covers the subject of medical law is Dada MA & McQuoid-Mason DJ (eds) *Introduction to medico-legal practice*, Butterworths, Durban (2001). It is relevant to both the Medical Law module and our module on Forensic Medicine (LCR403T). It could be useful as additional reading for this module. However, the book is not prescribed for examination purposes. When preparing yourself for the examination in this module, you may rely essentially on the content of this study guide.

In our library there are older South African works on medical law that you may wish to consult. There are also a number of foreign works, some of which were published recently, which may be of interest to you. If there is any subject in which you are particularly interested, we shall be glad to provide you with information on the available literature.

In reading cases and articles on medical law you may come across medical terms unknown to you. There are a number of excellent medical dictionaries. We recommend the following:

Levitt *Short encyclopaedia of medicine for lawyers* (1966)

Dorland's illustrated medical dictionary (latest available edition)

Snyman *Geneeskundige woordeboek 3 uitg* (1988) (bilingual)

Brink *et al Woordeboek van Afrikaanse geneeskundeterme* (1979)

The international journal *Medicine and Law* is a useful source of information on current developments in the field of medical law internationally. Articles on aspects of medical law are also published in general law journals.

Prescribed cases

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

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

Activities and feedback

You will find activities at the end of each study unit. Each activity is followed by feedback in which you receive guidance on furnishing the correct answer. Each activity should be regarded as an assignment for a particular study unit. The feedback will enable you to evaluate your answer.

Conclusion

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

STUDY UNIT 1

The Constitution and medical law

Contents

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

Activities

Feedback

Learning outcomes

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

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

1.1 Introduction

In this brief study unit we do not propose to discuss the right to health care and constitutional law in general in any great detail. That is a subject on its own which is deserving of close attention in a module on constitutional law. Here your attention is merely directed to certain provisions of the Bill of Rights contained in the Constitution, which took effect on 1 January 1997, relating to medical and health matters.

1.2 The prohibition of unfair discrimination

Section 9 (equality) prohibits unfair discrimination, *inter alia* on the ground of “disability”. Depending on the eventual interpretation of this clause by the Constitutional Court, the provision may be relied upon by, for example, persons with epilepsy, to challenge discrimination in the field of employment.

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

Section 9 of the latter Act prohibits discrimination on the ground of disability, including

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

Moreover, section 34 of Act 4 of 2000 imposes upon the authorities the obligation — in view of the “overwhelming evidence” of the impact of HIV/AIDS on society and the “systemic disadvantage” of and discrimination against people with HIV/AIDS — to consider further measures against such discrimination. The courts are, however, in the meantime empowered to decide that this form of disability is a prohibited ground of discrimination.

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

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

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

Note that the “Code of good practice: Key aspects of HIV/AIDS and employment” published (in GN R1298 GG 21815 of 1 December 2000) under the Labour Relations Act 1995 and the Employment Equity Act 1998 seeks, *inter alia*, to eliminate unfair discrimination in the workplace based on an employee’s HIV status.

1.3 The right to life

Section 11 provides that everyone has the right to life. This right is, of course, also protected by common law.

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

The right to life may also be relevant in the context of euthanasia. In terms of common law, assisted suicide and active euthanasia are considered unlawful.

Where an individual patient wants to have an end made to his/her intolerable suffering, it may be necessary to balance the state's constitutional obligation to protect life with the individual's right to control over his/her body (s 12(2)) and right to dignity (s 10).

1.4 The right to freedom and security of the person

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

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

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

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

In *Minister of Safety and Security v Xaba* 2004 (1) SACR 149 (D), the court held that a police official is not authorised in terms of the Criminal Procedure Act to use violence to obtain the surgical removal of a bullet from the leg of a criminal suspect for the purposes of evidence. In the absence of a law of general application authorising the constitutional infringements of the rights in section 12(1)(c) and section 12(2)(b), the requirements of the limitation clause could not be met.

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

The right to security in respect of and control over one's body is closely linked to the doctor's duty to obtain an informed consent before performing a medical intervention.

1.5 The right to privacy

Section 14 protects the right to privacy in general terms, and specifically mentions certain aspects of this right. Privacy is, of course, also protected by common law, and an example in the medical field is the patient's right to expect the doctor not to make unwarranted disclosures to others regarding the patient's ailment and the nature of the treatment. Section 14 will probably have little effect in the area of medical law because of existing common-law protection of privacy.

In *Mistry v Interim National Medical and Dental Council of South Africa* 1998 (4) SA 1127 (CC), a member of the public provided information to the Medical Council about a possible violation of the law by the applicant. The

Council passed on the information to an official who bore the statutory responsibility for carrying out regulatory inspections for the purposes of protecting the public health. The officials who dealt with the information, were subject to requirements of confidentiality. The court found that there had not been any violation of the applicant's right to privacy. The Constitutional Court considered the following factors to be important: whether the information was obtained in an intrusive manner; whether it was about intimate aspects of the applicant's personal life; whether it involved data provided by the applicant for one purpose, which was then used for another; whether it was disseminated to the press or the general public, or to persons from whom the applicant could reasonably expect such private information to be withheld.

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

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

1.6 The right to health care

Section 27 (dealing *inter alia* with health care) provides *inter alia* that

- (a) everyone has the right to have access to health-care services, including reproductive health care (s 27(1)(a))
- (b) no one may be refused emergency medical treatment (s 27(3))

See also the National Health Act 61 of 2003, section 5, which imposes a duty on doctors, nurses, hospitals, etcetera, in the following terms: "A health care provider, health worker or health establishment may not refuse a person emergency medical treatment." Note that there is nothing in this provision that would entitle a patient to receive such treatment **free of charge**.

In *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC) the court considered the meaning of the term "emergency medical treatment". Chaskalson P held that the purpose of the right not to be refused such treatment was that "[a] person who suffers a sudden catastrophe which calls for immediate medical attention ... should not be refused ambulance or other emergency services which are available and should not be turned away from a hospital which is able to provide the necessary treatment". What the constitutional provision required was that remedial treatment that was necessary and available, be given immediately in order to avert harm. Madala J was of the opinion that there "is some suddenness and at times even an element of unexpectedness in the concept emergency medical treatment".

In this case the patient suffered from chronic renal (kidney) failure. His life could, however, be prolonged by means of regular renal dialysis (blood purification by means of a machine). The hospital, a state institution, did not

have enough financial resources to provide dialysis treatment for all patients suffering from chronic renal failure. The cost of treating one chronically ill patient twice a week was approximately R60 000 per year. If the patient and others in the same condition were to be admitted to the hospital's dialysis programme, the "carefully tailored programme" would have collapsed, and no one would have benefited from that. The patient's condition simply was not so serious that it met the official guidelines.

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

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

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

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

provinces' antiretroviral policy also came up in *Treatment Action Campaign* cases reported in 2002 (5) SA 703 (CC), 2002 (5) SA 713 (CC) and 2002 (5) SA 717 (CC.)

The constitutional right to health care has been the subject of meticulous analysis by Pearmain DL in her doctoral thesis *A critical analysis of the law on health service delivery in South Africa* University of Pretoria (2004).

1.7 The rights of children

Section 28 (children) provides *inter alia* that every child has the right to basic health-care services. Undoubtedly the scope of this right will in due course be defined more closely by the Constitutional Court.

See also *Hay v B and Others* 2003 (3) SA 492 (W) which we discuss below in section 5.2.2.

1.8 The right to information

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

Everyone has the right of access to —

- (a) any information held by the state; and
- (b) any information that is held by another person and that is required for the exercise or protection of any rights.

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

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

1.9 The right to just administrative action

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

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

1.10 The rights of prisoners

Section 35, dealing with the rights of arrested, detained and accused persons, provides *inter alia* that such persons have the right to conditions of detention that are consistent with human dignity, including the provision of adequate

medical treatment at state expense. The section also guarantees the right of a detained person to communicate with and be visited by that person's chosen medical practitioner.

In *Van Biljon and Others v Minister of Correctional Services* 1997 (2) SACR 50 (C) the court ruled that the state owes a higher duty of care to HIV-positive prisoners than to citizens in general. Lack of funds cannot be an answer to a prisoner's constitutional claim to adequate medical treatment. Once a prisoner has been prescribed anti-viral treatment for AIDS, he is entitled to continue receiving the medication. But the decision whether or not to prescribe anti-viral treatment for the first time is a medical and not a legal decision.

Section 37, dealing with the declaration of a state of emergency, guarantees the right of a detainee to choose, and be visited at any reasonable time by, a medical practitioner (s 37(6)(c)).

ACTIVITIES

1. Discuss the various provisions of our constitutional Bill of Rights that relate to medical and health matters.
2. Discuss the constitutional rights protecting a person against unfair discrimination in respect of the medical situation.
3. Discuss the following constitutional rights of persons in the medical law context: the right to life, the right to freedom and security of the person, the right to privacy.
4. A contracts a very severe flu. She takes a taxi to the nearest provincial hospital and demands to be hospitalised and treated. Is there a constitutional duty on the hospital administration to accede to her demand? Discuss.
5. B is infected with HIV in consequence of unprotected sexual intercourse with a person who is HIV positive. Is B entitled to demand that a state hospital supplies her with antiretroviral treatment? Discuss.
6. Discuss the constitutional right of children and prisoners, respectively, to health care.
7. Discuss a citizen's rights to information and just administrative action, respectively, in the context of medical treatment and health care.

FEEDBACK

1. The activity as formulated requires a brief discussion of the entire contents of this study unit.
2. The prohibition of unfair discrimination is a key element of our constitutional Bill of Rights. A detailed discussion of the contents of part 1.2 of this study unit is required, with emphasis on section 9 of the Constitution and the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000, respectively.
3. See parts 1.3, 1.4 and 1.5 above.
4. Conclusions can be drawn from our discussion in part 1.6 above. Not any condition of ill-health would justify a demand to be

hospitalised. A case of flu *per se* does not justify the conclusion that the patient's case is one of a person who finds herself in a medical emergency.

5. In principle B would be entitled — in any event if she is indigent — to being supplied with antiretroviral treatment. But considering the scope of the HIV/AIDS pandemic in South Africa and the limited resources of the state, some balance must be struck between the entitlement of a patient and the duties of the state. The *Treatment Action Campaign* case, discussed in part 1.6 above must be carefully considered.
6. See parts 1.7 and 1.10 above.
7. Reasonableness is a key factor in this regard. See parts 1.8 and 1.9 above.

STUDY UNIT 2

The South African health-care system

Contents

- 2.1 Introduction
- 2.2 Regulation of Medical, Dental, Nursing and Supplementary Health Service Professions
- 2.3 Hospital and state medical services
- 2.4 Public health
 - 2.4.1 National Health Act 61 of 2003
 - 2.4.1.1 National Department of Health
 - 2.4.1.2 National Health Council
 - 2.4.1.3 National Consultative Health Forum
 - 2.4.1.4 Provincial health departments
 - 2.4.1.5 District health system
 - 2.4.1.6 National health research and information
 - 2.4.1.7 Health officers and compliance procedure
 - 2.4.2 Other legislation
- Activities
- Feedback

Learning outcomes

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

- demonstrate your knowledge of the basic legal principles applying to the health-care system in South Africa, both in the public and the private sector
- identify the most important acts of parliament which govern health services in South Africa in general

2.1 Introduction

In essence the South African system of health care is a non-socialised system. Although a substantial number of medical doctors and supplementary health-care professionals and the majority of nurses are employees of the national Department of Health, the provincial administrations and local authorities, most of the medical doctors, dentists, and pharmacists are not employed by the state but practise independently for their own account. Private practitioners and private hospitals attend to those who can afford to pay for the services they render, either from their own funds or through the medical scheme that they belong to. Medical schemes provide a form of medical insurance and are controlled in terms of the Medical Schemes Act 131 of 1998. Because of the relatively high costs involved, membership of medical schemes is to a large extent restricted to the more affluent. Employers often subsidise their employees' medical-scheme membership fees. As a

matter of policy, the national Department of Health hopes to make membership of medical schemes more affordable, to enable the high percentage of the South African population who are currently excluded, to enjoy the advantages of medical-scheme membership. According to the Department of Health, roughly between 75 and 80 percent of the population have limited access to health services (The Charter of the Health Sector of the Republic of South Africa, released by the Minister of Health on 28 October 2005, par 2.2.7.)

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

Notwithstanding the provisions of section 27 of the Constitution — to which we have referred above — the individual has no absolute right to health care in the sense that the state is legally obliged to provide such care and at its expense, irrespective of the economic status of the patient requiring medical or hospital services.

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

Another legal limitation upon the contents of the contract between doctor and patient is that a doctor may probably not enter into an agreement whereby the patient undertakes to assume the risk for negligent treatment (Strauss SA & Strydom MJ *Die Suid-Afrikaanse geneeskundige reg* (1967) 317). As yet we have not had a court decision on the legal validity of such an agreement, but the HPCSA will probably regard such an agreement as unethical.

2.2 Regulation of Medical, Dental, Nursing and Supplementary Health Service Professions

The medical, dental, nursing and supplementary health service professions are not state-controlled, but the law makes provision for registration by professional councils or boards and for the control by these boards of standards of conduct for practitioners. The Health Professions Act 56 of 1974 governs medical and dental practitioners as well as health-service personnel

such as psychologists, occupational therapists, chiropractors, physiotherapists, medical technologists, optometrists, orthopaedic orthotists and prosthetists, radiographers, speech therapists, dieticians and food inspectors.

The nursing profession is governed by the Nursing Act 50 of 1978 (which will be repealed and replaced by the Nursing Act 33 of 2005 when it comes into operation), the pharmacy profession by the Pharmacy Act 53 of 1974, dental technicians by the Dental Technicians Act 19 of 1979, and practitioners such as chiropractors, homeopaths, naturopaths, osteopaths, herbalists and certain other categories of health practitioners by the Allied Health Professions Act 63 of 1982. The Traditional Health Practitioners Act 35 of 2004 was assented to on 7 February 2005. This Act is aimed at regulating traditional healers. However, on 17 August 2006, the Constitutional Court in *Doctors for Life International v Speaker of the National Assembly and Others* Case CCT 12/05 declared Act 35 of 2004 invalid on the basis that the National Council of Provinces did not comply with its obligation to facilitate public involvement in relation to this Act. The order of invalidity was suspended for a period of 18 months to enable parliament to enact this statute afresh in accordance with the provisions of the Constitution.

All the Acts referred to make registration or enrolment on a professional register or list a prerequisite for the practice of the branch of medicine or technology involved, and penalise practice by an unregistered person. (Note that in terms of the Health Professions Act 56 of 1974, it is a criminal offence for an unregistered person to undertake certain forms of treatment, even where it is not for gain, eg to treat cancer.)

Limitations are placed on the scope of activities that may be undertaken by members of a particular profession, except in the case of medical practitioners and dentists.

As far as medical practitioners are concerned, the only statutory limitation imposed upon their practice is that a doctor who is not registered as a dentist may not perform acts pertaining to dentistry except in cases of emergency or where no dentist is readily available (s 38, Act 56 of 1974). Furthermore there is the rule of professional ethics whereby it is improper conduct for a doctor or dentist to perform professional acts for which he is inadequately trained and/or insufficiently experienced (except in an emergency). Under common law a practitioner who performs such acts may be held liable for the damage or injury suffered by the patient as a consequence of these acts, on the basis of negligence. The South African Medical and Dental Council (the predecessor of the HPCSA) made a rule whereby registered specialists may not perform acts which do not belong to their speciality.

2.3 Hospital and state medical services

Although there is no national health service in South Africa of the type operative in England, provision has been made for state and provincial hospitals and clinics to offer medical and hospital services for the lower-income groups and indigent persons either free or at a reduced rate.

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

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

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

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

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

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

Private hospitals in principle have an absolute discretion concerning whom they will admit as patients. It is submitted, however, that in a case of a life-or-death emergency, where there is no state hospital within easy reach, a private hospital which is equipped with a casualty section may by common law be obliged to admit the patient involved. This view is supported by section 27 of the Constitution which provides *inter alia* that no-one may be refused emergency medical treatment. See also *Soobramoney's case* 1998 (1) SA 765 (CC) discussed above in study unit 1. Section 5 of the National Health Act 61 of 2003 makes it clear that a “health establishment” may not refuse a person emergency medical treatment. “Health establishment” includes the whole or part of a private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services.

This part need NOT be studied for examination purposes.

2.4 Public health

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

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

2.4.1 National Health Act 61 of 2003

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

- establishing a national health system which encompasses public and private health-care providers, and provides the population of the Republic in an equitable manner with the best possible health services that available resources can afford
- setting out the rights and duties of health-care providers (doctors and other registered health-care professionals, nurses, pharmacists, dental technicians, etc), health workers, health establishments (hospitals, clinics, nursing homes, diagnostic centres, etc) and users (ie patients and clients)
- protecting and promoting the rights of people to realise the constitutional right of access to health care, to a safe environment, the rights of children to basic nutrition and health-care services, and the rights of vulnerable groups such as women, children, the elderly and disabled persons

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

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

The important duty is further imposed on the Minister to determine eligibility for free health services in public health establishments — section 4.

2.4.1.1 National Department of Health

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

measures and integration of health plans of the national department and provincial departments.

2.4.1.2 National Health Council

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

2.4.1.3 National Consultative Health Forum

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

2.4.1.4 Provincial health departments

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

2.4.1.5 District health system

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

2.4.1.6 National health research and information

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

2.4.1.7 Health officers and compliance procedure

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

2.4.2 Other legislation

There are a number of other acts of parliament dealing with public health, in the broader sense of the word, or aspects thereof, namely the Mental Health Care Act 17 of 2002, the Foodstuffs, Cosmetics and Disinfectants Act 54 of 1972, the Hazardous Substances Act 15 of 1973, the Medical Schemes Act 131 of 1998, the Housing Act 107 of 1997, the National Environmental Management: Air Quality Act 39 of 2004, the Dumping at Sea Control Act 73 of 1980, the International Health Regulations Act 28 of 1974, the Prevention and Treatment of Drug Dependency Act 20 of 1992, the Tobacco Products Control Act 83 of 1993, the National Health Laboratory Service Act 37 of

2000 and the Council for Medical Schemes Levies Act 58 of 2000. In addition to these there are laws of the various provinces and by-laws of municipal councils dealing with hospitals, local health affairs and incidental matters.

ACTIVITIES

1. Discuss the basic juristic nature of the South African health-care system.
2. Discuss the general features of hospital and medical services offered by the state.
3. Discuss the broad functions of the National Health Act 61 of 2003.

FEEDBACK

1. The essence the South African system of health care is non-socialised. This means that it is largely private-sector oriented. The citizen has no absolute right to health care.
2. South Africa does not have a state-run national health service. But provision has been made for medical and health services to be provided free or at a reduced cost to indigent persons.
3. The National Health Act sets out the broad framework within which the Department of Health and other official bodies must or may act to promote the health of the general public.

STUDY UNIT 3

Regulation of the medical profession by the law

CONTENTS

Parts 3.1 to 3.4
need **NOT** be
studied for
examination
purposes.

- 3.1 Introduction
 - 3.2 The Health Professions Council of South Africa (HPCSA)
 - 3.3 Professional boards
 - 3.4 Registration of practitioners
 - 3.5 Compulsory community service
 - 3.6 Continuing education may be required
 - 3.7 Practice by unregistered persons prohibited
 - 3.8 Unprofessional conduct
 - 3.9 Disciplinary powers of professional boards
 - 3.10 Appeal against adverse disciplinary finding, and review
 - 3.11 Restrictions on impaired students or practitioners
 - 3.12 Practitioners' charges
 - 3.13 Various provisions relating to medicines prescribed for or supplied by patients
 - 3.13.1 Dispensing of medicines
 - 3.13.2 Generic substitution
 - 3.13.3 Commissions
 - 3.13.4 "Bonusing" and "sampling" outlawed
 - 3.14 Anaesthetic deaths
 - 3.15 Medical and health records
 - 3.16 Discharge reports
 - 3.17 Complaints by patients
 - 3.18 Duties of patients to comply with rules
 - 3.19 Rights of doctors and other health care personnel
- Activities
- Feedback

Learning outcomes

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

- discuss the statutory machinery that was set up to exercise control over the registration of health professionals such as doctors, and to ensure that high ethical standards were maintained
- explain what parliament has enacted to prevent unqualified persons from practising as doctors and thus exploiting the public
- discuss the important statutory prohibitions intended to protect the public against exploitation by suppliers of medicine
- set out the correct legal procedure that must be followed in cases of "anaesthetic deaths"

3.1 Introduction

The Health Professions Act 56 of 1974 is the "charter" of the medical

practitioner in South Africa. However, it goes beyond the medical doctor in that it also governs the practice of dentistry and psychology, and supplementary health services apart from nursing, midwifery, pharmacy, homeopathy and chiropractic.

Examples of those who supply such supplementary services are occupational therapists, chiropodists, physiotherapists, medical technologists, optometrists, orthopaedic orthotists and prosthetists, radiographers, psychotechnicians, speech therapists and audiologists, blood-transfusion technicians, optical dispensers, dieticians, electro-encephalographic technicians, medical physicists, health assistants, haematology technicians, histopathology technicians, masseurs, microbiology technicians, oral hygienists, orthoptists, audiometrists, remedial gymnasts, cytotechnicians, food inspectors, biomedical engineers, supplementary diagnostic radiographers, community speech- and hearing-workers, teachers of the speech- and hearing-impaired, clinical technologists, oral hygienists, speech- and hearing-correctionists, radiation technologists, medical scientists, clinical biochemists, dental therapists, physiotherapy assistants, dental hygienists and orthopaedic-footwear technicians.

3.2 The Health Professions Council of South Africa (HPCSA)

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

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

- (1) to co-ordinate the activities of the professional boards established in terms of the Act
- (2) to promote and to regulate interprofessional liaison between registered professions in the interest of the public
- (3) to determine strategic policy with regard to the professional boards and the registered professions, for matters such as finance, education, registration, ethics and professional conduct, disciplinary procedure, scope of the professions, interprofessional matters and maintenance of professional competence
- (4) to consult and liaise with relevant authorities on matters affecting the professional boards in general
- (5) to assist in the promotion of the health of the population of the Republic
- (6) to control and to exercise authority in respect of all matters affecting the training of persons in, and the manner of the exercise of the practices pursued in connection with, the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in humankind
- (7) to promote liaison in the field of training referred to in (6) above, both in the Republic and elsewhere, and to promote the standards of such training in the Republic
- (8) to advise the Minister on any matter falling within the scope of this Act in order to support the universal norms and values of health professions, with greater emphasis on professional practice, democracy, transparency, equity, accessibility and community involvement
- (9) to communicate to the Minister information of public importance

acquired by the HPCSA in the course of the performance of its functions under this Act

The HPCSA may establish such committees as it may deem necessary, including disciplinary committees (also known as “professional conduct committees”). The HPCSA may delegate to a committee any or some of its powers, but is not divested of a power thus delegated.

Special provision is made for the establishment of *ad hoc* disciplinary appeal committees. Such a committee must be chaired by a retired judge or retired senior magistrate, or an attorney or advocate with at least 10 years’ experience (s 10).

On disciplinary committees (also known as “professional conduct committees”) and disciplinary appeal committees, see below.

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

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

3.3 Professional boards

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

So far 12 such boards have been established (GN R75 of 16 January 1998, GG 18608).

They are the

- Professional Board for Speech, Language and Hearing Professions
- Professional Board for Dental Therapy and Oral Hygiene
- Professional Board for Psychology
- Professional Board for Occupational Therapy and Medical Orthotics/Prosthetics
- Professional Board for Physiotherapy, Podiatry and Biokinetics
- Professional Board for Radiography and Clinical Technology
- Professional Board for Medical Technology
- Professional Board for Environmental Health Officers
- Professional Board for Emergency Care Personnel
- Professional Board for Optometry and Dispensing Opticians
- Professional Board for Dietetics
- Medical and Dental Professional Board (which now performs many of the functions of the old Medical Council, the difference being that it deals exclusively with medical practitioners and dentists and, of course, with the training of medical and dental students)

3.4 Registration of practitioners

No person may practise the profession of medical practitioner, dentist, psychologist or as an intern, or any other registerable profession, unless he or she is registered in terms of the Health Professions Act 56 of 1974 (s 17(1)(a)). Excepting nurses and midwives, chiropractors and the like, and pharmacists, the Act further prohibits the practising for gain of any profession (unless the person concerned is registered in terms of the Act), the practice of which consists mainly of the following (s 17(1)(b)):

- (1) the physical or mental examination of persons
- (2) the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in man
- (3) the giving of advice in regard to such defects, illnesses or deficiencies
- (4) the prescribing or providing of medicine in connection with such defects, illnesses or deficiencies

The Act makes provision for separate registers to be kept in respect of medical practitioners, dentists, interns, student interns, medical students, dental students, psychologists, intern-psychologists and psychology students, and other health professionals (s 18(1)). The Act further contains detailed provisions on applications for registration (s 17). The HPCSA must make recommendations to the Minister regarding the qualifications which will entitle persons to practise.

The Minister may, in consultation with the HPCSA, by regulation make provision for registration of persons qualified outside the Republic, on the basis of what the HPCSA regards as a satisfactory standard of professional education. The HPCSA may require foreign graduates to pass an evaluation. The Minister may, in consultation with the HPCSA, make regulations concerning the imposition of restrictions on the practice of foreign graduates (s 25).

A person not permanently resident in the Republic may be registered as a medical practitioner, dentist or psychologist in South Africa for the purpose of promoting medical, dental or psychological education, or to undergo training for the practising of a supplementary-health-service profession (s 29), or to enable that person to engage in postgraduate studies (s 30). The Act makes provision for the registration of specialities (s 35). A non-resident who is registered, may give demonstrations in approved institutions.

Provision is made for administrative removal from the register of names on grounds not relating to improper conduct, for example absence of the person concerned for three years from the Republic, failure to notify the Registrar of a change of address, failure to pay annual fees, etcetera (s 19).

Any person who is aggrieved by any decision of the HPCSA, a professional board or a disciplinary committee, may appeal to the High Court against such decision. Notice of appeal must be given within one month from the date of the decision (s 20).

Study from here to the end of the study unit for examination purposes.

3.5 Compulsory community service

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

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

3.6 Continuing education may be required

The HPCSA may make rules which prescribe

- conditions relating to continuing education and training to be undergone by practitioners in order to retain registration
- the nature and extent of such education and training
- the criteria for recognition of continuing education and training courses (s 26 of the Health Professions Act 56 of 1974)

In 1999 continuing education became compulsory for medical practitioners. They are required to earn through approved programmes 250 “continuing professional development” (CPD) points over a 5-year period.

In terms of section 22 registration certificates remain valid for one year only; thereafter “annual practising certificates” will be issued on payment of the required annual fee and the submission of certain information with a statistical value, required by the HPCSA (s 26).

3.7 Practice by unregistered persons prohibited

It is a criminal offence for an unregistered person to practice **for gain** as a **medical practitioner** (whether or not purporting to be registered) (s 36(1)(a) of the Health Professions Act 56 of 1974). This prohibition does not, of course, preclude registered nurses and pharmacists, health personnel acting under the Health Act 63 of 1977, registered chiropractors, homeopaths or similar registered professionals from performing such professional services as they are entitled to perform by virtue of their professional status.

In addition to the general provision against an unregistered person practising as a medical practitioner, the Act (s 36(1)(b)) also declares punishable a series of individual acts performed **for gain**. These are the following:

- (1) physically examining any person
- (2) performing any act of diagnosis, treatment or prevention of any physical defect, illness or deficiency
- (3) advising any person on his or her physical state
- (4) on the ground of information provided by any person or obtained from him or her, diagnosing such person’s physical state, advising him or her on his or her physical state, or supplying, selling to or prescribing for such person any medicine or treatment
- (5) prescribing or providing any medicine, substance or thing

- (6) performing any act specially pertaining to the profession of a medical practitioner

In *S v Aandeweg* 1986 (1) SA 211 (C) the court had to decide whether the acts of a spinologist who examined a person's spine by running his fingers up and down the spine, and, having found that it was not correct, applied pressure on the spine with his hands and fingers, amounted to (1) examining a person, (2) performing an act of diagnosing, treating or preventing any physical defect, illness or deficiency, or (3) advising any person on his physical state. Regarding (1), the court held that there had been an examination, but the examination referred to in the Act must mean an examination of a medical nature, in other words for purposes of diagnosis and treatment. The Act does not prohibit the examination of the muscular state of a potential client by a gym instructor or of the face by a beautician. Regarding (2), the court held that the spinologist did not diagnose because he did not seek to find the cause of a pathological condition or to recognise a disease or illness. On the question whether the spinologist performed any act of "treating or preventing any defect, illness or deficiency", the court was of the opinion that, although it cannot be denied that he treated the person, the issue was whether this treatment related to a "defect, illness or deficiency". The court held that the deficiency or defect must be in the nature of an illness. The spinologist performed an act of treating or preventing a deficiency or defect, but the deficiency or defect was not in the nature of an illness or of a medical nature. The act was performed to improve or correct the alignment or the relationship of the vertebrae, and the spinologist did not contravene section 36(1)(b). The court also rejected the view that the spinologist advised the person on his physical state.

Furthermore it is an offence for any unregistered person to diagnose, treat or prevent any physical defect, illness or deficiency in any person, and, by virtue of such act, **to obtain either for himself, or for another person, any benefit.** "Benefit" is defined very widely as including any benefit by way of any profit from the sale or disposal of any medicine, foodstuff or substance, or by way of any donation or gift, or by way of the provision of accommodation, or the obtaining of (either for himself or another) any other gain whatsoever (s 36(1)(c)). Persons performing any of these acts in accordance with the provisions of the Medicines and Related Substances Act 101 of 1965, the Pharmacy Act 53 of 1974, the Health Act 63 of 1977, the Nursing Act 50 of 1978, the Chiropractors, Homeopaths and Allied Health Service Professions Act 63 of 1982, and sections 33, 34 and 39 of the Health Professions Act 56 of 1974, do not make themselves guilty of the offence created in section 36(1)(c) of the Health Professions Act 56 of 1974.

It is further a criminal offence to pretend to be a medical practitioner, intern, or healer of whatever description, of physical defects, illnesses or deficiencies in man (s 36(1)(d)).

Any unregistered person who uses the name of "medical practitioner", "intern", "healer" "doctor", etcetera, is guilty of an offence (s 36(1)(e)). The prohibition on the use of the term "doctor" does not prevent a chiropractor, homeopath, etcetera, to use the title "Dr". The prohibition is aimed at preventing a person who is not registered from using a title or name

indicating, or calculated to lead persons to infer, that he or she is qualified or registered as a medical practitioner. There are thousands of persons in disciplines totally unrelated to medicine who hold doctorates; merely by calling themselves “doctor” they do not purport to be a medical practitioner. The title of “doctor” in any event does not enjoy legal protection. Cf *R v Butler* 1937 (1) PH K29. (The word “doctor” originated in the Latin word “docere” which means “to teach”. Some of the most famous “doctores” were the teachers of law in the ancient Italian university in Bologna, in the twelfth century AD.)

In terms of section 36(1)(f), it is a punishable offence for any person not registered under the Act to hold himself or herself out to be able, qualified or competent to diagnose, treat, or prevent physical defects, illnesses or deficiencies in man, or to prescribe or supply any medicine, substance or thing in respect of such conditions, **even where it is not for gain**. Persons performing any of these acts in accordance with the provisions of the Medicines and Related Substances Act 101 of 1965, the Pharmacy Act 53 of 1974, the Health Act 63 of 1977, the Nursing Act 50 of 1978, the Chiropractors, Homeopaths and Allied Health Service Professions Act 63 of 1982, and sections 33, 34 and 39 of the Health Professions Act 56 of 1974, do not make themselves guilty of the offence created in section 36(1)(f).

Finally, it is an offence for an unregistered person, **even where it is not for gain**, to diagnose, treat or offer to treat, or to prescribe a cure for cancer, or to hold oneself out to be able to treat or cure cancer or to prescribe treatment, or to maintain that an article, compound, medicine or apparatus is, or may be, of value for the alleviation, curing or treatment of cancer (s 36(1)(g)).

A conviction of any of the aforesaid criminal offences may lead to a fine, or to imprisonment for a period not exceeding twelve months, or to both such fine and such imprisonment. These criminal provisions are not applicable to interns performing any function or issuing such documents or certificates as may be issued by medical practitioners, and describing themselves for that purpose as medical practitioners (s 36(2)(a)). Student interns are not prohibited from performing these acts in the course of their training under the supervision of a medical practitioner, or from issuing the required documents in respect of the performance of those acts (s 36(2)(aA)). Furthermore, these provisions do not apply to pharmacists or dentists acting within the scope of their respective professions (s 36(2)(b) and (c)).

Similar provisions to those set out above are applicable to dentists (see s 38). It is to be noted that the Dental Technicians Act 19 of 1979 defines certain acts which may be performed only by dentists (see s 27). The Health Professions Act 56 of 1974 further contains severe penalties concerning the practising of any supplementary-health-service profession by unregistered persons (s 39). The prohibition on practising by an unregistered person in a supplementary-health-service profession naturally does not affect medical practitioners, dentists and nurses, who may lawfully render services which to a certain extent will overlap with those rendered by supplementary-health-service personnel.

The Health Professions Act 56 of 1974 further penalises unregistered persons practising **for gain** as psychologists (s 37(1)(a)). Section 37(1)(b) prohibits the

performance, **for gain**, by a person who is not registered of the same specified acts listed under section 36(1)(b) (see above, the acts numbered (1)–(6)), but substitute the word “mentally” for “physically”, “mental” for “physical”, and “psychologist” for “medical practitioner”. Section 37(1)(b)(vi) prohibits the performance of any other act specially pertaining to the profession of a psychologist. Subsection (2) provides that, for the purposes of subsection (1), the following acts are deemed as acts specially pertaining to the profession of a psychologist:

- (1) the evaluation of behaviour or mental processes or personality adjustments or adjustments of individuals or of groups of persons, through the interpretation of tests for the determination of intellectual abilities, aptitude, interests, personality make-up or personality functioning, and the diagnosis of personality and emotional functions and mental-functioning deficiencies according to a recognised scientific system for the classification of mental deficiencies
- (2) the use of any method or practice aimed at aiding persons or groups of persons in the adjustment of personality, emotional or behavioural problems, or at the promotion of positive personality change, growth and development, and the identification and evaluation of personality dynamics and personality functioning according to psychological scientific methods
- (3) the evaluation of emotional, behavioural and cognitive processes or adjustment of personality of individuals or groups of persons by the use and interpretation of questionnaires, tests, projections or other techniques or any apparatus, whether of South African origin or imported, for the determination of intellectual abilities, aptitude, personality make-up, personality functioning, psychophysiological functioning or psychopathology
- (4) the exercising of control over prescribed questionnaires or tests or prescribed techniques, apparatus or instruments for the determination of intellectual abilities, aptitude, personality make-up, personality functioning, psychophysiological functioning or psychopathology
- (5) the development of and control over the development of questionnaires, tests, techniques, apparatus or instruments for the determination of intellectual abilities, aptitude, personality make-up, personality functioning, psychophysiological functioning or psychopathology
- (6) the use of any psychotherapeutic method, technique or procedure to rectify, relieve or change personality, emotional, behavioural or adjustment problems or mental deficiencies of individuals or groups of people
- (7) the use of hypnosis and hypnotherapy
- (8) the use of any psychological method or counselling to prevent personality, emotional, cognitive, behavioural and adjustment problems or mental illnesses of individuals or groups of people

All these acts listed in section 37(1)(b) may be performed **for gain** by registered psychologists or intern-psychologists only. Unregistered persons who perform such acts for gain are criminally punishable. However, there are a number of bodies and persons who may perform the acts specially pertaining to the profession of a psychologist (listed (1)–(8) above). They are the following (s 37(4)(a)):

- (1) educational, training or research institutions recognised by the professional board and the HPCSA
- (2) members of the academic staff of a university, technikon, training institution or teachers on the staff of a school, established under a law in the ordinary course of education or research in education

The following persons and bodies may, in terms of section 37(4)(b)–(g), perform any of the acts listed in section 37(1):

- (1) medical practitioners, in the ordinary course of the practice of their profession
- (2) nurses, in the ordinary course of the practice of their profession
- (3) social workers, or those acting under their supervision
- (4) a person holding office in a religious denomination which exists for the purpose of worshipping, provided the act is performed for that purpose and in accordance with the normal pastoral practice of that denomination
- (5) students at universities or other prescribed institutions, working under the supervision of a psychologist
- (6) persons performing duties as prescribed by regulation under the supervision of, or on the instructions of, a psychologist
- (7) organisations recognised by the professional board and the HPCSA, rendering services as prescribed by regulation for the aid of persons with personal problems

However, the persons who are exempted are restricted as follows: academics or teachers may not treat a mental illness; social workers and ministers of religion may not conduct psychological tests or undertake the treatment of a mental illness (s 37(5)).

As far as nurses are concerned, we must draw your attention to the provisions of section 37(1)(c), in terms of which the diagnosis, treatment or prevention of a mental defect, illness or deficiency in a patient is not an offence in so far as a nurse performs her duties in accordance with the provisions of the Nursing Act.

Intern-psychologists are exempted in respect of the issuing of certificates (s 37(3)).

No remuneration is recoverable in respect of any act specially pertaining to the profession of a registered person when performed by an unregistered person. Unregistered persons are further disqualified from holding professional appointments, apart from students or trainees employed in hospitals (s 59).

The act of a pharmacist selling a non-prescription medicine such as cough medicine, headache tablets or a stomach powder to a client who tells him what his ailment is, naturally does not involve diagnosis, and the pharmacist is then not guilty of contravening section 36. See, for example *R v Van der Heim* 1914 TPD 434, 436; *R v Smith* 1917 TPD 206, 208. The same applies to a supermarket assistant or a medicine hawker recommending a patent medicine to a customer.

3.8 Unprofessional conduct

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

A professional board has the power to institute an inquiry into any complaint, charge or allegation of unprofessional conduct against persons registered under the Act (s 41(1)). In practice the boards delegate the power of inquiry to a professional conduct committee (formerly known as a “disciplinary committee”).

In effect, a professional board is the sole repository of the power to decide what is ethical and what is unethical in medical practice — *Pretorius v SA Geneeskundige en Tandheekundige Raad* 1980 (2) SA 354 (T); *Meyer v SA Medical and Dental Council* 1982 (4) SA 450 (T). This power must, however, be exercised subject to the values protected by the Constitutional Bill of Rights, including the right to just administrative action.

The HPCSA must, in consultation with a professional board, from time to time make rules specifying the acts or omissions in respect of which a board may take disciplinary steps. (An important provision in the Act is that the power of inquiry is not limited to acts or omissions so specified.) Such rules must first be approved by the Minister of Health and published in the Government Gazette before they become operative (s 49(1)).

Such rules have been made and published in the Government Gazette 29079 of 4 August 2006, No R717. We do not intend to discuss in detail the rules of conduct laid down from time to time for medical practitioners, dentists, psychologists and practitioners of supplementary health services such as optometrists and occupational therapists, but merely wish to mention the categories of rules currently pertaining to doctors and dentists in general.

These categories are the following: advertising and canvassing or touting; information to be included on professional stationery; the naming of a practice; itinerant practice; fees and commission; partnership and juristic persons; covering; supersession; impeding a patient from obtaining the opinion of another practitioner or from being treated by another practitioner; casting reflections on the professional reputation of colleagues; professional confidentiality; retention of human organs; the signing of official documents; certificates and reports, and the information they should contain; issuing of prescriptions; professional appointments; secret remedies; defeating or obstructing the HPCSA or board in the performance of its duties; performance of professional acts; exploitation; medicine; financial interest in hospitals; reporting of impairment or of unprofessional, illegal or unethical conduct; research, development and use of chemical, biological and nuclear capabilities; and dual registration.

There is a duty upon a court of law to bring to the attention of the professional board concerned *prima facie* proof of unprofessional conduct on the part of a practitioner which was disclosed in the course of a court trial (s 45(2)). Where a registered person, either before or after registration, has been convicted of any offence by a court, he may be dealt with by the

professional board under its disciplinary powers if the board is of the opinion that such offence constitutes unprofessional conduct. However, before imposition of any penalty, the person in question must be afforded an opportunity to tender an explanation to the professional board in extenuation (s 45(1)).

The disciplinary powers of a professional board are not restricted to the conduct prohibited by the published rules (s 49(1)).

If *prima facie* proof of unprofessional conduct is submitted to a professional board, a legal obligation arises to conduct an inquiry (*Veriava v President, SA Medical and Dental Council* 1985 (2) SA 293 (T)). See also *VRM v Health Professions Council and Others* 2003 TPD (unreported as yet).

3.9 Disciplinary powers of professional boards

As mentioned above, a professional board is vested with the power of instituting an inquiry into alleged unprofessional conduct against registered practitioners. In the case of a complaint, charge or allegation which forms the subject of a criminal case in a court of law, the board may postpone the holding of an inquiry until the court case has been determined (s 41(1) of the Health Professions Act 56 of 1974). In practice, disciplinary inquiries are conducted by a professional conduct committee, since the professional board has delegated its powers to the professional conduct committee. (Professional conduct committees are also known as “disciplinary committees”.)

Provision is made for the appointment of a special investigating officer to investigate, *inter alia*, the affairs of a registered person. See section 41A. The provisions of that section are strictly interpreted in order to guard against an unwarranted interference with the rights of a practitioner. See *Mistry v INMDC and Others* [1997] 3 All SA 519 (D&CLD).

A professional board may, where a professional practitioner is found guilty of unprofessional conduct, impose one of the following penalties (s 42(1)):

- (1) a caution or reprimand, or a reprimand and caution
- (2) suspension for a specified period from practising or performing acts specially pertaining to a practitioner’s profession
- (3) removal of a practitioner’s name from the register
- (4) a fine not exceeding R10 000
- (5) a compulsory period of professional service
- (6) payment of the costs of the proceedings or a restitution

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

Note that if a professional board is of the opinion that a fine (as determined by the Minister) should be imposed after a conviction following an allegation of unprofessional conduct, an “admission of guilt” summons may be issued. The accused practitioner may then admit his guilt, if he so wishes, without appearing at an inquiry (s 42(8)–(9)).

A practitioner whose conduct is the subject of an inquiry must himself be afforded an opportunity of answering the charge and of being heard in his own defence or of having his legal representative (ie attorney or advocate)

answer for him (s 42(2)). The professional board may take evidence and summon witnesses (s 42(4)(a)). The procedure to be applied in the case of inquiries is set out in Government Notice R765 of 24 August 2001.

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

A professional board has the power to postpone the imposition of a penalty or to impose a penalty but order the execution of such penalty or any part of the penalty to be suspended. Conditions for such postponement or suspension may be set (s 43(1)).

The effect of a practitioner's suspension or the removal of his name from the register is that he is disqualified from carrying on his profession. His registration certificate is deemed to be cancelled until the period of suspension has expired or until his name has been restored to the register by the professional board (s 44). Should he continue to practise, he may become liable to be prosecuted under the criminal provisions applying to unregistered persons.

3.10 Appeal against adverse disciplinary finding, and review

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

- (1) An appeal may be lodged to an *ad hoc* appeal committee appointed by the Health Professions Council (s 10 of the Health Professions Act 56 of 1974). The appeal committee may vary, confirm or set aside a finding of a disciplinary committee, or may refer the matter back to the disciplinary committee with such instructions as it may deem fit (s 10(3)).
- (2) An appeal may be lodged to the High Court against a decision of the Council itself, a professional board or a disciplinary appeal committee, by any person who is aggrieved by a decision of such a body (s 20(1)). Notice of appeal must be given within one month from the date on which such decision was given (s 20(2)).

On the face of it, the *pro forma* complainant acting for the professional board will also be entitled to appeal, that is against a finding of the disciplinary committee, which may include a finding of "not guilty".

In due course the courts will undoubtedly be called upon to decide what kind of appeal the legislature had in mind. "Appeal" is not necessarily confined to a rehearing of the merits on the basis of the evidence heard by the disciplinary committee, and may also allow the hearing of fresh evidence by the disciplinary appeal committee or the High Court itself.

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

Apart from the statutory right of appeal, an aggrieved practitioner may take the proceedings of a professional board on review to the High Court by virtue

of the common-law powers of a review of that court. Review procedure may be directed largely at the manner in which the professional board (or its disciplinary committee) has arrived at its findings. A review may, however, also be considered on the basis of the substance and merits of an adverse finding (see *Roman v Williams* NO 1998 (1) SA 270 (C)).

3.11 Restrictions on impaired students or practitioners

The Minister may, in consultation with the HPCSA, make regulations relating to inquires in respect of students or persons registered in terms of the Act who appear to be impaired, on the assessment of their condition, the conditions to be imposed on their registration or practice, their suspension or removal, from practising, revocation of conditions, suspension or removal, and on acts of unprofessional conduct committed before or during assessment or investigation (s 51 of the Health Professions Act 56 of 1974).

“Impaired” for the purposes of this section means “a mental or physical condition, or the abuse of or dependence on chemical substances, which affects the competence, attitude, judgment or performance of a student or person registered in terms of [the] Act” (s 1).

3.12 Practitioners’ charges

The Health Professions Act 56 of 1974 requires practitioners to furnish patients with a detailed account within a reasonable period (s 53(2)). A patient may, within three months after receiving an account, apply in writing to a professional board to determine what a reasonable fee would be (s 53(3)(a)). A claim referred to the board is not recoverable until a determination has been made, and then only to the extent of the determination (s 53(4)). Apart from such action, the board may still take disciplinary action against the practitioner involved (s 53(5)).

See further part 4.1.2 below.

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

3.13.1 Dispensing of medicines

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

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

(1) The practitioner must have successfully completed a supplementary

course determined by the South African Pharmacy Council after consultation with the Health Professions Council of South Africa, the Allied Health Professions Council of South Africa and the South African Nursing Council (s 22C(2)).

- (2) A licence may be issued “on the prescribed conditions”, that is prescribed by way of ministerial regulations (s 22C(1)(a)).
- (3) An application fee is payable (s 22C(1)(a)).
- (4) The licence will be valid for the prescribed period only and must be renewed by way of application, for which a fee is also payable (s 22D).
- (5) The Director-General is given the power to suspend or revoke a licence on grounds such as failure to comply with a condition imposed (s 22E).

The issuing of dispensing licences to practitioners is governed by GN R510 GG 24727 of 10 April 2003. In terms of regulation 18 a formal application must be made to the Director-General. The applicant must advertise his or her intention to apply for such a licence in a newspaper circulating in the relevant area.

In considering an application the Director-General must have regard *inter alia* to representations made by other interested persons as to whether a licence should be granted or not (reg 18(b)). In *Affordable Medicines and Others v Minister of Health* 2005 (6) BCLR 529 (CC), the Constitutional Court held that the statutory precepts governing the licensing of dispensing doctors were valid in principle. However, these provisions do not empower the Department of Health to refuse an application for a licence on the ground that there are pharmacies in the neighbourhood.

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

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

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

3.13.2 Generic substitution

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

A pharmacist or dispensing doctor must inform all patients who present a prescription of the benefits of generic substitution, or, as the Medicines and Related Substances Act 101 of 1965 puts it, “of an interchangeable multi-source medicine” (s 22F(1)(a)). The pharmacist must also dispense a generic medicine for the medicine prescribed by the doctor, unless the patient has

expressly forbidden substitution (s 22F(1)(b)). Such prohibition must then be noted on the script by the pharmacist. If a substitute is dispensed by the pharmacist, he must note it in his prescription book (s 22F(2)).

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

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

(“Interchangeable multi-source medicine” is defined by the latter Act, s 1, as “medicines that contain the same active substances which are identical in strength or concentration, dosage form and route of administration and meet the same or comparable standards, which comply with the requirements for therapeutic equivalence as prescribed”.)

3.13.3 Commissions

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

3.13.4 “Bonusing” and “sampling” outlawed

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

“Sampling”, again, is defined as “the free supply of medicines by a manufacturer or wholesaler or its agent to a pharmacist, medical practitioner, dentist”, or certain other categories of practitioners. The prohibition does not, however, include the free supply of medicines for the purpose of clinical trials (s 18B of Act 101 of 1965).

3.14 Anaesthetic deaths

The death of a patient whilst under the influence of a general or a local anaesthetic, or to which the administration of an anaesthetic has been a contributory cause, is not deemed to be a death from natural causes as contemplated by the Inquests Act 58 of 1959 or the Births and Deaths Registration Act 51 of 1992. The effect of this provision is that an inquest must invariably take place following such a death before a death certificate can be issued by a medical practitioner (s 56 of the Health Professions Act 56 of 1974).

3.15 Medical and health records

The National Health Act 61 of 2003 contains detailed provisions relating to the keeping of patient records by hospitals and other “health establishments”. See for example section 13 on the obligation to keep record, section 14 on confidentiality of patient information, section 15 on access to health records, section 16 on access to health records by health care providers, and section 17 on protection of health records. “Health establishment” is defined in such wide terms in the Act that it undoubtedly also includes the practice of private practitioners.

It goes without saying that it is a matter of extreme importance for doctors — and their patients — to keep adequate records of the treatment of all patients. The entries made in patient files will often be of the utmost importance when the patient seeks the services of another doctor, or in the event of civil actions for damage, or for Health Professions Council of South Africa disciplinary inquiries.

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

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

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

3.16 Discharge reports

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

3.17 Complaints by patients

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

3.18 Duties of patients to comply with rules

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

3.19 Rights of doctors and other health care personnel

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

Every health establishment must implement measures to minimise injury or damage to the person or property of health-care personnel working in the establishment, and disease transmission.

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

ACTIVITIES

1. Discuss the formal structure of the system which was set up to exercise control over the practice of medicine and supplementary health personnel in South Africa such as psychologists and physiotherapists.
2. Discuss the prohibition against the practice of medicine, psychology and other forms of recognised medical and health care by unregistered persons.
3. Discuss the concept of “unprofessional conduct” in the medical profession, and the disciplinary powers of professional boards of the HPCSA. Also state the rights of professionals charged with unprofessional conduct.
4. Discuss the limitations on dispensing of medicines by doctors.
5. Discuss the statutory provisions pertaining to generic substitution of medicines, the payment of commissions to doctors for prescribing certain medicines, and so-called “bonusing” and “sampling” in connection with the distribution of medicines.

FEEDBACK

- | |
|--|
| <ol style="list-style-type: none"> 1. The Health Professions Council of South Africa (HPCSA) was set up by statute to control the practice of medicine, psychology and a range of other health services. Information on the structure and the |
|--|

- functioning of the HPCSA is to be found in the Health Professions Act 56 of 1974, discussed in considerable detail in this study unit.
2. See in particular part 3.7 above in which the statutory provisions relating to unregistered health practitioners are dealt with in detail.
 3. Taking action against registered medical and health practitioners for ethically unacceptable behaviour (“unprofessional conduct”) is one of the major functions of the HPCSA and is discussed in detail in this study unit.
 4. Details are provided in part 3.13.1 of this study unit.
 5. See parts 3.13.2, 3.13.3 and 3.13.4 above.

STUDY UNIT 4

Contractual relations

Contents

- 4.1 The contract between doctor and patient
 - 4.1.1 Mutual rights and duties
 - 4.1.2 Medical fees
- 4.2 Mutual contractual relations between doctors
 - 4.2.1 “Associate practice”
 - 4.2.2 Medical practice by means of companies
 - 4.2.3 Practice in medical and health “networks”
 - 4.2.4 Covenants in restraint of trade
 - 4.2.4.1 Content
 - 4.2.4.2 Object of clause
 - 4.2.4.3 Validity and enforceability
 - 4.2.4.4 Summary of principles
 - 4.2.4.5 Examples
 - 4.2.4.6 Penalty clause

Activities

Feedback

Learning outcomes

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

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

4.1 The contract between doctor and patient

4.1.1 Mutual rights and duties

As we have mentioned, a patient in consulting a doctor enters into a contractual relationship with him.

A doctor in private practice is a free agent or independent “contractor”, and can generally accept or refuse patients as he chooses. But where a person finds himself in a dire emergency where his life or health will be seriously endangered unless he receives immediate medical treatment, a doctor who is available may neither ethically nor, it is submitted, legally, refuse to attend the patient, unless there are compelling circumstances which prevent the doctor

from acting. (The SA Medical and Dental Council has ruled that ethically “in cases of emergency, a practitioner is obliged to render assistance under all circumstances”.) On the legal and ethical position, see Strauss *Doctor, patient and the law* 3 ed (1991) at 23 et seq; Nathan C in Bosman F (ed) *Welfare law* (1982) 395; *Magware v Minister of Health* NO 1981 (4) SA 472 (Z).

We again draw your attention to section 27 of the Constitution which provides that no-one may be refused emergency medical treatment. Section 5 of the National Health Act 61 of 2003 makes it clear that a “health care provider” or “health worker” may not refuse a person emergency medical care. A “health care provider” is a person providing health services in terms of any law, including the Health Professions Act 56 of 1974, the Nursing Act 50 of 1978, and the Allied Health Professions Act 63 of 1982. A “health worker” is a person, other than a health care provider, who is involved in the provision of health services to a user. These provisions confirm the common-law duty which in our opinion rests on these persons.

Doctors and nurses who are employees of a public hospital may not refuse to attend to a particular type of patient, such as a patient with AIDS. (“AIDS” is the abbreviation for “acquired immuno-deficiency syndrome”.) The SA Nursing Association also ruled in 1988 that it would be unethical for a nurse to refuse to attend to patients with AIDS. The SA Medical and Dental Council made a similar ruling in 1991 in respect of doctors (see 1991 *SAMJ* vii (16.11.91)). (These ethical rulings, it is to be noted, apply generally and not only to nurses or doctors employed by hospitals.)

By common law, however, there is a duty upon an employer to take reasonable measures to ensure that its employees work in safe conditions. A hospital authority accordingly should inform its employees duly on what steps to take to avoid contracting serious infectious diseases from patients. The hospital should also furnish its employees with the equipment reasonably required to avoid unnecessary health risks. It is submitted that the duty of health personnel to treat patients does not go so far as to entitle the hospital to require that its personnel provide unprotected mouth-to-mouth resuscitation to patients who may be HIV-infected. (“HIV” is the abbreviation for “human immunodeficiency virus”, that is the virus which causes AIDS.)

Ordinarily the contract entered into by the parties takes the form of a tacit agreement whereby the doctor undertakes to diagnose the patient’s complaint and to treat him for the complaint in the accepted manner. Any unusual procedures contemplated by the doctor should first be discussed with the patient. An undertaking on the part of the doctor to examine the patient and to diagnose his condition does not amount to an undertaking on the part of the doctor to personally treat the patient. As is frequently the case, the doctor may decide to refer the patient to a specialist.

By diagnosing and treating a patient, a doctor does not guarantee that the patient will be cured of his disease (see the judge’s remarks in *Buls and Another v Tsatsarolakis* 1976 (2) SA 891 (T) at 893; see also *Thake and Another v Maurice* 1986 (1) All ER 497 (CA); *Behrmann and Another v Klugman* 1988 (4) SA Practice Management 6 (W)). In *Chalk v Fassler* (1995 WLD, unreported) the judge remarked that no comparison can be drawn between an agreement to repair a car and an agreement to treat a patient

medically. In the light of modern technology motor cars are generally repairable if reasonable care and skill are used; surgery, however, holds the risk of failure.

Should a doctor be so unwise as to expressly guarantee a cure, the patient might be able to claim damages for breach of contract in the event of the doctor's failing to fulfil his undertaking. **Ordinarily, however, the doctor undertakes no more than to treat the patient with the amount of skill, competence and care which may reasonably be expected of a practitioner of his branch of medicine.**

If a doctor departs from the patient's express instructions or fails to treat the patient in the manner tacitly agreed upon, the doctor will be guilty of breach of contract and may be denied the right to claim remuneration for his services, for example a dentist furnishing a patient with ill-fitting dentures (*Sutherland v White* 1911 EDL 407), a doctor who has undertaken to perform an operation upon a patient, handing the patient over to another doctor (because of a golf appointment which the first-mentioned doctor has made in the meantime) (*Recsei's Estate v Meine* 1943 EDL 277), or a doctor who has undertaken to forward for analysis a biopsy taken of a tumour in a patient's nose, through negligence causing the biopsy to be lost (*Hewat v Rendel* 1925 TPD 679).

In *Administrator of Natal v Edouard* 1990 (3) SA 581 (A) a hospital authority was held liable for damages resulting from a breach of contract in that the hospital doctors had failed to carry out an undertaking to perform a tubular ligation (sterilisation) on a woman; subsequently she fell pregnant and gave birth to a child.

A patient's claim against a doctor for negligent treatment does not necessarily depend on proof of the existence of a contract. The patient may also sue on the basis of a delict having been committed (*Correia v Berwind* 1986 (4) SA 60 (Z)).

Once the treatment has been commenced, the doctor may not simply abandon the patient. But if a course of treatment has been completed, the agreement comes to an end and the doctor need not attend to the patient any longer (*Kovalsky v Krige* (1910) 30 CTR 822).

The patient must perform his part of the agreement by making himself available for treatment. Should he fail to do so, however, the doctor cannot in any way force him to submit to treatment. But a patient who fails to present himself for an appointment may be held liable by the doctor for the financial loss (if any) caused by such failure. In practice this would normally mean that the patient could become liable for the fee which the doctor would have earned for the service less any sum he had actually earned or could reasonably have earned during the period set aside for the defaulting patient (see *Myers v Abrahamson* 1952 (2) SA 121 (C) at 127).

Specific provisions relating to the cancellation of appointments with medical practitioners were contained in the rules accompanying the tariff of fees for members of medical schemes, recommended annually by the SA Medical Association (SAMA), prior to 2003. It was provided that unless timely steps are taken to cancel an appointment for consultation, the relevant consultation

fee may be charged. In the case of a general practitioner “timely” was defined as two hours, and in the case of a specialist 24 hours prior to the appointment. It was provided, however, that “each case shall ... be considered on merit and, if circumstances warrant, no fee shall be charged” (rule D of the general rules). Although this provision did not have statutory force, medical schemes and doctors generally applied it. It may be argued that the practice has become common law on the basis of “trade usage”.

4.1.2 Medical fees

As we have mentioned under 3.12 above, a doctor is not entitled to charge any fee he wishes to charge, or which the patient is willing to pay. The fee must be reasonable.

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

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

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

A claim referred to the Board is not recoverable until a determination has been made, and then only to the extent of the determination. Apart from such action, the Board may still take disciplinary action against the practitioner involved. Please note that for the purposes of section 53 “professional services” include the supply and fitting of any artificial part of the human body.

A doctor (or other health-care provider) who has rendered a service to a member of a medical scheme (“medical aid” as it is popularly known) or a dependant of a member, must render to the member a detailed account — Medical Schemes Act 131 of 1998, section 59(1). The details required are set out in regulation 5 of the Medical Schemes Act regulations (embodied in GN R1262 of 20 October 1999, as amended). Where an account has been rendered, the medical scheme must pay within 30 days of receipt of the account, to the member or doctor such benefit as is payable to the member or doctor — Medical Schemes Act 131 of 1998, section 59(2). A medical scheme may not refuse to pay a benefit as a result of late submission of an account before the end of the fourth month from the last date of the service rendered — regulation 6. Provision is also made in regulation 6 for correction of erroneous statements.

Note that there is nothing in the Medical Schemes Act or the regulations thereunder which compels a scheme to pay benefits directly to a health-care provider such as a doctor. If, however, a doctor's fees are in accordance with the tariff of benefits accepted by a scheme, the scheme will ordinarily pay the doctor directly. (There is no longer a system of "guaranteed payment" as far as doctors are concerned.)

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

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

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

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

It is necessary to point out that regardless of the scale according to which the doctor charges his or her fees, it is the patient who in the final analysis remains liable for the settlement thereof. (There is no contract between the doctor and the medical scheme.) Patients who are members of medical schemes, however, enjoy the advantage — as was mentioned above — of the scheme paying the doctor directly if the doctor's fees are charged on a tariff scale acceptable to the medical scheme.

Medical schemes commonly require their members to pay specified cash levies in respect of medicines dispensed by pharmacists and services rendered by certain health-care providers, such as doctors and hospitals.

4.2 Mutual contractual relations between doctors

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

4.2.1 “Associate practice”

In the past doctors who wished to practise jointly frequently formed partnerships, and many continue to do so. (Note that a partnership is not a company.) Partners share profits as well as losses in accordance with an agreed ratio. One of the advantages of a partnership is that if a partner falls ill or takes a vacation, his income does not “dry up”, because he continues to share in the income generated by the other partner or partners. (In passing we should mention that s 30(1) of the Companies Act 1973 limits the membership of a partnership to 20. During 1996 the Minister of Trade and Industry agreed to exempt doctors, dentists, psychologists and members of supplementary health service professions from the limitation.)

There are also certain disadvantages flowing from partnerships. Relations may become strained if one of the partners does not pull his weight in the practice and the other partners begin to feel that he profits unfairly from their hard work. The insolvency of one of the partners may also create problems for the other partner(s).

For these reasons, *inter alia*, the custom arose for doctors to practise in the form of a kind of free “association”. (Unless duly registered as a company — see below — such an association is not a company.)

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

In such agreements provision is also made for doctors in the “association” to take leave in an agreed order, and the others to then take responsibility for such a doctor’s patients. The important characteristic, however, is that profits are not pooled, and therefore no separate estate arises, as would be the case with a partnership.

Doctors who practise in “association” also occasionally form companies to possess and control independent assets. For example, fixed property on which consulting rooms are situated may be owned by a company in which doctors are individual shareholders. A company offers advantages, for example the transfer of shares on retirement of a member of the “association”. Sometimes assets such as a holiday house are also purchased and controlled by a company in the interests of the members of the “association”.

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

4.2.2 Medical practice by means of companies

In terms of the Health Professions Act 56 of 1974, corporate practice, that is constitution of a practice in the form of a registered company having limited

liability, is generally prohibited for doctors. The Minister of Health may, however, on the recommendation of the Health Professions Council, exempt any juristic person or class of juristic persons from any of the provisions of the Act in order to enable such juristic person to practise a profession regulated by the Act. Conditions for such practice may be specified in the notice (s 54A, introduced in 1992).

The current conditions for practice in corporate form are contained in GN R706, GG 15627 of 15 April 1994. We discuss here only some of the salient points.

The company must be incorporated and registered as a private company in terms of the Companies Act 1973, with a share capital.

The company's memorandum and articles of association must provide that the directors and past directors shall be liable jointly and severally, together with the company, for debts and liabilities of the company incurred during their term of office. This is an important point of difference between "doctors' companies" and typical commercial companies. In an ordinary company the shareholders' liability is limited to the amount of their shareholding. Generally speaking shareholders and directors can incur other liability only if they have signed personal guarantees for the company's debts.

Only doctors and members of supplementary health service professions registered under the Health Professions Act 56 of 1974 can be shareholders and directors of such a company. A corporate member of the company may not control more than 24 percent of the share capital issued. Each shareholder remains personally subject to the provisions of the Act and the disciplinary powers of the Council.

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

There could also be some tax advantages.

Note that in terms of the Companies Act private companies may not have more than 50 members (with exceptions in favour of employees or former employees).

4.2.3 Practice in medical and health "networks"

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

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

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

Such a company will then enter into agreements with medical schemes in terms of which the members of a medical scheme (or members who have selected a particular benefit option) will have access to health-care providers at the centre at a fixed reduced rate. These agreements are known as “capitation” agreements. Such an agreement essentially means that the medical scheme pays the company a pre-negotiated fixed fee for arranging the delivery of specified medical benefits.

Capitation agreements form an important part of “managed health care”, which is defined by the regulations under the Medical Schemes Act 131 of 1998 as “clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable ...”. Amongst other things the clinical necessity of particular procedures is critically assessed. Managed health-care organisations must be formally accredited by the Council for Medical Schemes.

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

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

4.2.4 Covenants in restraint of trade

Sometimes contracts between professional persons contain a restraint clause, and as this is an important topic, we discuss it here in some detail.

4.2.4.1 Content

When a medical practitioner employs a professional assistant, it often happens that the medical practitioner insists on including a condition in the agreement between them to the effect that upon termination of the agreement, the assistant will not be entitled to practise for a certain period within the general geographical area in which the medical practitioner practises. Partnership agreements may also contain similar conditions favouring senior partners above their juniors (or, on occasion, a restraint clause regarding the senior partner in favour of the remaining partners). Also, when a medical practitioner sells a practice, the purchaser frequently insists on a similar condition in his favour.

Such restrictive clauses — popularly known as “bar clauses” or “restraint clauses” and in the law reports called “agreements or ‘covenants’ in restraint of trade” — obviously feature not only in agreements between doctors, but also in a variety of other contracts, such as those between legal practitioners, accountants, architects, dealers, consulting engineers, etcetera.

4.2.4.2 *Object of clause*

The object of a restraint clause is self-evident: a senior practitioner has through his skill and ardour established a practice with such success that he needs assistance. With a view to this, he obtains the services of a young practitioner. Through being employed in this way the young practitioner is introduced to a large number of patients gained by the senior over a number of years. In time, the junior can also win the confidence of patients.

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

4.2.4.3 *Validity and enforceability*

The justifiability of safeguarding against future competition is recognised in principle by our courts. In *Weinberg v Mervis* 1953 (3) SA 863 (C), which dealt with the validity of a restraint clause in a contract in which one practitioner had sold his practice to another, the judge remarked as follows (at 868 of the report):

I have never understood the law to be that the purchaser of goodwill can protect himself from competition by the seller in respect only of the existing clientele at the time of the contract of sale. What the purchaser is entitled to do is to protect himself against the seller's future competition in regard to activities normally falling within the confines of the type of business bought by the purchaser.

And at 870 of the report:

In the present type of case where the avowed object of the purchaser of the goodwill is to protect himself against the future competition of the vendor, one is not concerned only with the persons who are the patients of the practice at the time of the sale, but with potential patients.

See also *Forman v Barnett* 1941 WLD 54, 63.

This type of clause has often been a subject of dispute resulting in litigation. In the past, the courts approached these clauses with considerable aversion because they could harm free trade (or professional activity). In fact, the point of departure of our courts was that such clauses were in principle null and void, and that the onus was on the person who wanted to enforce the clause — the ex-employer, senior partner or seller of a business or practice — to persuade the court that the restraint was reasonable and, therefore, enforceable. Since 1977, however, starting with the decision of the Natal full bench in *Roffey v Catterall, Edwards & Goudré (Pty) Ltd* 1977 (4) SA 494 (N), a more favourable attitude on the part of our courts became noticeable. In 1984, in the important decision of *Magna Alloys and Research (SA) (Pty) Ltd v Ellis* 1984 (4) SA 874 (A), the Appellate Division put its seal of approval on the new approach.

4.2.4.4 Summary of principles

The legal position may now be summarised as follows:

In principle, a clause in a contract which restricts a party's freedom to trade is not invalid and unenforceable. It is a principle of our law, however, that covenants which are not in the public interest cannot be enforced.

A covenant which restricts someone's freedom to trade is against public policy (and therefore unenforceable) if the circumstances of the case are such that the court is of the opinion that enforcement thereof would harm the public interest.

It may be assumed that a limitation of someone's freedom to trade which is unreasonable (ie unreasonable to him) would probably be harmful to the public interest as well, if it were to be enforced against the person involved. This would be the case where the person protected by the restraint (eg senior partner) has no practical interest in enforcing the restraint (eg where the senior partner himself stopped practising after dissolution of the partnership).

The person who alleges that he is not bound by a restraint clause — usually the former assistant or junior partner — bears the onus of proving that enforcement thereof would be against the public interest. He must therefore allege facts and adduce evidence on which he bases his attack on the validity of the restraint.

The court must have regard to the circumstances existing at the time when it is requested to enforce the restraint. (This represents an important new point of view because the courts, in earlier cases, held the view that the reasonableness or otherwise of the restraint was to be assessed in the light of circumstances existing at the time when the agreement was entered into. Changed circumstances may accordingly be of importance nowadays.)

The court is not limited to a finding that a restraint is enforceable (or unenforceable) in its entirety, but is entitled to decide that only a part of such clause is enforceable (or unenforceable). This, too, represents an important new point of view considering the fact that, in earlier decisions, the courts were not prepared to endeavour to “carve” from a void restraint the maximum upon which the protected party could have insisted; the entire clause was simply held to be null and void. This latter rule was cast aside in *Magna Alloys*, and the new principle is much more equitable.

Note that the *Magna Alloys* decision is of retroactive effect in the sense that it affects all existing contracts containing restraint clauses. In *Turner Morris (Pty) Ltd v Riddell* 1996 (4) SA 397 (E) the court reduced the area which would have been covered by a generally worded limitation.

In order to decide whether or not a restraint agreed upon by the parties to a contract is reasonable, the courts will have regard particularly to circumstances such as whether the area in respect of which the restraint operates, is unreasonably wide, whether the period is unreasonably long, and whether the scope of the activities from which the aggrieved party is excluded, is unreasonably wide. A restraint clause is not open to attack, however, purely on the ground that it is of unlimited duration.

Every case is dealt with on its own merits. In considering the public interest,

the court will have regard to, *inter alia*, the availability of similar, alternative services. In order to avail himself of the restraint clause, the protected party must fulfil his obligations in terms of the agreement (eg as purchaser of a practice, by paying the purchase price).

In the past the courts, in requiring the protected party (eg former employer) to prove that the public interest would not be harmed by the restraint, attached considerable importance to the question of whether the contracting parties were more or less on an equal footing, for example as practitioners of more or less equal, independent status (see eg *Malan & Andere v Van Jaarsveld en 'n Ander* 1972 (2) SA 243 (C)). If they were, this fact afforded strong evidence that the restraint was reasonable. This factor is no longer of any particular significance. In *Roffey* the Natal court pointed out that with the advent of trade unions, economic progress and other modern phenomena (such as protective labour legislation) the modern employee may be in a more powerful negotiating position than the employer.

It is doubtful whether the inclusion of an acknowledgement of the reasonableness of a restraint of trade in a service contract will *per se* be of much significance should a dispute arise (*Wuhl (Pty) Ltd and Others v Badler and Another* 1984 (3) SA 427 (W)).

In *Kotze en Genis (Edms) Bpk en 'n Ander v Potgieter en Andere* 1995 (3) SA 783 (C) it was argued that the *Magna Alloys* case no longer reflects the legal position with regard to restraint clauses, in view of section 26(1) of the interim Constitution which guaranteed the individual's right to freely engage in economic activity. The court was urged to rule that restraint clauses were *prima facie* null and void, and that the favoured party should bear the onus of proving that the restraint was reasonable. The court refused, however, to uphold this argument. Conradie J held that it would be unacceptable to find that the entire approach must be changed merely because the Constitution also said that freedom of trade was a laudatory objective. For decades already the courts had protected the right of persons to freely engage in economic activity.

The 1996 Constitution does not contain a provision which is similar to that of section 26(1). Section 22 of the 1996 Constitution, however, guarantees the right of every citizen to choose his or her trade, occupation or profession freely. The practice of a trade, occupation or profession may be regulated by law.

In *Coetzee v Comitis and Others* 2001 (1) SA 1254 (C) the facts were as follows: C, a professional football player, was a member of Ajax Football Club. He wanted to move to another team after Ajax informed him that there were no prospects for him to play for Ajax any longer following his recovery from physical injuries. In terms of the National Soccer League (NSL) rules, for the transfer to be effected, C had to apply to his team for a clearance certificate. He applied for it, but his team's management refused to grant it. His team was entitled, in terms of NSL rules, to compensation if he registered with a new team, which entitlement would cease only if he did not participate in competitive football for 30 months after the expiry of his contract.

The court held that the NSL rules violated the basic values underlying the Constitution, including the freedom of trade. According to the court the onus

lay with the respondents to show that the compensation regime constituted a reasonable and justifiable limitation in an open and democratic society based on human dignity, equality and freedom, taking into account all factors. The court did not hesitate to hold that the compensation regime constituted an unreasonable restraint of trade, and that it should be declared inconsistent with the Constitution and, therefore, invalid.

The latter case deals essentially with the compensation aspect, rather than a covenant in restraint of trade as discussed by us above, and the court's ruling is not necessarily in conflict with *Kotze's* case.

The last word on the constitutionality of restraints of trade is yet to be spoken. Compare *Fidelity Guards Holdings (Pty) Ltd t/a Fidelity Guards v Pearmain* 2001 (2) SA 853 (SEC).

4.2.4.5 Examples

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

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

For a survey of earlier decisions of our courts in cases other than those involving medical practitioners, see Strauss & Strydom 153 *et seq.*

From the decisions quoted above — and many others in which persons other than doctors were involved — it is clear that an endeavour on the part of a doctor to protect himself with regard to an exceptionally large area and for an indefinite period, may lead to the court's finding the restraint invalid, or limiting it to a reasonable extent. If the restraint concerns a rare kind of speciality practised by only a few doctors in the country, however, a large area would not readily be held to be unreasonable. A case in point would be *Pest*

Control (Central Africa) Ltd v Martin 1955 (3) SA 609 (SR), where a restraint clause for the whole of Zimbabwe, Zambia and Malawi for a period of two years in respect of a specialised commercial activity where the potential number of clients was small, was upheld.

4.2.4.6 Penalty clause

Before concluding our discussion on covenants in restraint of trade, it must be pointed out that a penalty clause is sometimes attached to such a covenant.

A penalty clause is a provision in terms of which a party who acts in contravention of a contractual obligation is liable to pay a sum of money to the innocent party (the creditor), whether by way of penalty or as liquidated damages: Conventional Penalties Act 15 of 1962. Such a penalty clause is enforceable.

However, the creditor is not entitled to claim damages in addition to the penalty sum; he may also not claim damages in lieu of the penalty sum, unless the particular contract expressly so provides. If, upon the hearing of a claim of a penalty sum, it appears to the court that the penalty sum is out of proportion to the loss suffered by the creditor as a result of the breach of contract, the court may reduce the penalty to the extent it may consider equitable in the circumstances.

An example of a penalty clause attached to a restraint clause is found in *Weinberg v Mervis* 1953 (3) 863 (C). There the purchaser of a practice protected himself by way of a stipulation that if the vendor contravened the restraint clause, he would have been liable to payment of three guineas (the equivalent of perhaps R130 or R160, today) to the purchaser in respect of each breach.

It is to be noted that the penalty clause should be as specific as possible — as in the case referred to. (The penalty clause in that case was formulated “as fixed liquidated and genuinely pre-estimated damages **and not by way of a penalty**” (our emphasis). The latter qualification has become superfluous since the enactment of Act 15 of 1962. Before the Act, “pure” penalty clauses *eo nomine* were not enforceable; what was enforceable was a genuine stipulation of pre-estimated damages. Act 15 of 1962 rendered this distinction obsolete.)

ACTIVITIES

1. Dr A, who performs an operation on patient B, guarantees to her that “the operation will be absolutely successful and you will be permanently rid of your complaint”. It turns out that the operation only partially cures patient B and that some of the problems still persist. Discuss whether B may sue Dr A for damages.
2. The usual fee for a particular type of operation performed by a specialist surgeon is R1 500. After performing the operation, the surgeon tells the patient that “it has been extraordinarily tricky” and charges a fee of R3 500. Discuss whether the patient can take any steps against the surgeon to cut his fee.

3. Discuss the various ways in which doctors who wish to practice jointly can achieve this objective.
4. Dr X, a young doctor, enters into a partnership with a senior and established doctor, Dr Y. Dr X insists upon a clause being inserted into the partnership contract stipulating that upon Dr Y leaving the practice, she (Dr Y) will not be entitled to practice in an area with a radius of 75 km from the current address of the practice, for a period of five years. Discuss the enforceability of such a clause.

FEEDBACK

1. Mere acceptance of a patient by a doctor for treatment does not amount to a guarantee to cure the patient. Nor would encouragement of the patient by the doctor “not to worry, we’ll fix your health” amount to a contractual guarantee. If, however, a doctor were to undertake expressly to achieve a specified result, it might perhaps be construed as a guarantee; failure to produce a successful result might then conceivably be seen as a breach of contract. See part 4.1.1 above.
2. Charging an excessive fee may land the doctor in trouble. First, if no advance warning was given to the patient, the latter may contend that there has been a tacit agreement between the parties that the doctor’s fee would not exceed the usual fee. If the fee charged is unreasonably excessive, the patient may lodge a complaint with the HPCSA, with the consequences as described in part 4.1.2 above.
3. The three usual forms of joint practice are (a) partnership, (b) associate practice or (c) practice by means of a “section 54A company”. In part 4.2 above the main advantages and disadvantages of these forms of practice are discussed briefly. We also discuss briefly the so-called “medical network” system.
4. South African case law has “mapped out” in considerable detail the validity of these “covenants in restraint of trade”. In principle they are enforceable unless unreasonably stringent or against the public interest. Depending upon whether the present clause involves general practitioners or specialists, the area of restriction as well as the period may be rather too restrictive. A court is entitled to “scale down” both the area and the term. You will have to reach a definite answer by looking at the basic principles described above in part 4.2.4 as well as the examples from case law given by us.

STUDY UNIT 5

The legal basis of medical intervention

Contents

- 5.1 Consent as ground of justification
 - 5.1.1 A duty to heal?
 - 5.1.2 A professional right to heal?
 - 5.1.3 Consent to injury: general criteria
- 5.2 The concept of consent
 - 5.2.1 General
 - 5.2.1.1 Substituted consent
 - 5.2.1.2 Treatment without consent
 - 5.2.2 Minors
 - 5.2.3 Mental patients
 - 5.2.3.1 General
 - 5.2.3.2 The Mental Health Care Act 17 of 2002
 - 5.2.4 Spouses
- 5.3 The doctor's duty to inform the patient
 - 5.3.1 General requirements
 - 5.3.2 Tests, including HIV/AIDS tests, and informed consent
 - 5.3.3 National Health Act 61 of 2003 and informed consent
- 5.4 Doctor deviating from operation consented to
- 5.5 Medical intervention without consent in emergencies

Activities

Feedback

Learning outcomes

- When you have completed this study unit, you should be able to
- apply the basic legal principles that justify medical procedures
 - determine whether there rests a legal duty upon a doctor to heal a patient
 - judge whether a doctor has a legal right to treat patients merely by virtue of his professional status, or whether there are other factors which determine the doctor's right to treat
 - describe what medical consent entails
 - describe what the legal requirements are with regard to special categories of patients such as minors and the mentally ill
 - identify the limits within which a doctor may deviate from a procedure agreed upon with the patient
 - explain the principles pertaining to medical procedures performed in emergency situations where the patient is unable to consent

5.1 Consent as ground of justification

5.1.1 A duty to heal?

To begin with, we want to discuss the question whether the physician is under a general duty to act and to treat a patient. In terms of the ethics of the profession, such an obligation clearly exists. Although such a duty is not expressly imposed by the **Oath of Hippocrates** (which originated in ancient Greece and is named after the father of medicine in the West), this oath contains a truly positive purport with regard to the practice of medicine. According to the Geneva Declaration of 1948, which is a modern version of the Hippocratic Oath, the physician must solemnly swear these words, among others: “I shall treat human life with the greatest respect ...; even when I am deceived, I shall not exercise my knowledge of medicine in conflict with the laws of humanity.” The International Code of Medical Ethics of 1949 prescribes this among other things: “A physician must always keep in mind the obligation to safeguard human life.”

Whatever the moral or ethical consequences may be for a physician who refuses to give medical help to a sick or injured person, it may be stated that generally he would not incur criminal or delictual liability merely by virtue of such refusal. For example, take the physician who arrives by chance at the scene of an accident. His help could save the injured person from death and from serious, perhaps permanent, harm to health. Suppose that the physician neglects to provide medical help. As a general rule he would apparently not be liable. Voet *Commentarius ad pandectas* 9.2.3 states expressly that a doctor who refuses to render treatment cannot be held liable under the Lex Aquilia. Smith HW (*Rocky Mountain LR* (1942) 233) states:

In order to protect a doctor’s discretion, and to make him the sole judge of his competency as well as the privilege of choosing his patients, the law has held that a physician may arbitrarily refuse employment by one who is in dire need of medical care.

The classic case in America is *Hurley, Administrator v Eddingfield* 156 Ind 416 (1901). The deceased person was seriously ill and sent a messenger to the physician with a fee in order to secure his services and to tell him that there was no other physician available. There was no other patient to occupy the physician’s immediate attention at the time but he nevertheless refused to come to the assistance of the deceased — and gave no reason for refusing. The sick man later died. In an action instituted by the deceased’s dependant, the court held that the doctor had acted completely lawfully. On appeal, the court expressed itself in the following terms:

The act regulating the practice of medicine ... is a preventive, not a compulsive, measure. In obtaining the State’s licence (permission) to practice medicine, the State does not require, and the licensee does not engage, that he will practise at all or on other terms than he may choose to accept. Counsel’s analogies, drawn from the obligations to the public on the part of innkeepers, common carriers, and the like, are beside the mark.

In certain countries express statutory provision impose positive duties of a

general nature upon persons to avert harm from another in cases where this can be done without personal harm to the subject concerned. But our courts in earlier years adopted an individualistic approach and did not recognise a general duty to act so as to avert harm from others. The traditional approach was that a person could not be held liable by virtue of a mere *omissio*. This view is no longer held. Today it is accepted that a mere *omissio* can in fact lead to delictual as well as criminal liability where the circumstances are such that the person concerned could reasonably be expected to intervene. See *Regal v African Superslate (Pty) Ltd* 1963 (1) SA 102 (A); *S v Russell* 1967 (3) SA 739 (N); *Minister van Polisie v Ewels* 1975 (3) SA 590 (A) 597A.

In *Ewels* the Appeal Court stated as follows:

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

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

A court might conceivably find that a physician's failure to act in any particular situation besides those discussed below, makes him criminally liable because reasonableness demands that he ought to have acted. However, it is submitted that a court will arrive at such a decision only after considerable circumspection, because here we are concerned with services of a specialised nature where a physician might doubt his own ability. Besides, he may have so many patients already that in their interest he ought not reasonably to be obliged to accept any more, or he may at the time in question be in a state of such utter exhaustion that it may be unreasonable to make any further demands on him. See further Strauss 23–8 in this regard.

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

- (1) Where the perpetrator, by a positive action, creates a potentially dangerous situation, and then later neglects to take precautions to avert the danger (the so-called *commissio per omissionem*).

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

Some of the situations in point might also possibly be classified under the doctrine of *negotiorum gestio*. One of the principles of our law is that if someone voluntarily intervenes in order to safeguard the interests of another without authorisation by the last-named party, then he is subject to certain obligations. One of these is that the *negotiorum gestor* is under an obligation to complete what he began. Once he has undertaken to further the interests of another, he cannot merely abandon his undertaking. We shall return to *negotiorum gestio* below.

- (2) Where a person accepts control of a dangerous object and subsequently fails to exercise proper control over it.

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

In South Africa this principle has been applied to several decisions. See McKerron RG *The law of delict* 7 ed (1971) 20–23 and the judgments quoted there; Neethling et al 56–58. The following instance might be an analogous one in the practice of medicine. A, a physician, is engaged in giving a blood transfusion to C. He is urgently needed somewhere else and asks B, a colleague who happens to be present, to temporarily take his place. B fails to exercise proper control over the process or instrument, and C dies in consequence of this. B may be criminally liable.

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

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

- (3) Where an obligation to act is imposed on a person by a specific statutory provision.

Examples of this would be the obligation which regulations may impose on a medical officer to vaccinate persons who come for vaccination, and the duty inherent in the constitutional provision (s 27(3)) and the National Health Act 61 of 2003 (s 5) that no one be refused emergency treatment. (See 1.6, above, where the important *Soobramoney* case is also discussed.) The common-law position as set out in *Ewels* above has been bolstered by the provision in our Constitution contained in the Bill of Rights (s 27(3)), namely that “no one may be refused emergency medical care”. It is submitted that this prohibition is binding on health-care personnel in both the public and private sector. In any event, the provisions of section 5 of the National Health Act 61 of 2003 prohibiting health care providers, health workers and health establishments from refusing a person emergency medical treatment are clearly applicable to health-care personnel and hospitals in both the public and private sector. Clearly, the professional called upon to render emergency treatment in a serious, life-threatening situation requiring immediate action would not be entitled to refuse doing so unless there are compelling reasons for refusing or failing to act.

- (4) Where a person, by agreement, has taken certain obligations upon himself.

A legal duty of this kind can arise from a contract of employment. An example is the physician in the service of a hospital authority. His contract with the authority obliges him to provide medical services in a certain section of the hospital (the casualty section, for example) where he must render medical aid to the victims of accidents or assaults who are brought in for treatment. The scope of his duties depends on the terms of the contract of employment. If the contract restricts the physician’s duties to specific times or functions, failure to provide medical services to patients outside the times agreed upon, or to perform functions other than those agreed upon, will not normally make him liable.

It goes without saying that a duty to act arises in regard to patients with whom the physician has contracted to provide medical services. See Voet 9.2.3. This is the ordinary obligation that every physician in private practice undertakes. A breach of such a duty can make the physician liable both criminally and delictually. In *Administrator, Natal v Edouard* 1990 (3) SA 582 (A), a hospital failed to perform the agreed tubal ligation during the course of a caesarean section. This rendered the hospital liable for the maintenance and support of a child born as a result of the failure.

In *Buls and Another v Tsatsarolakis* 1976 (2) SA 891 (T) the court made the following observation:

Generally speaking every man has a right that others shall not injure

him in his person and that involves a duty to exercise proper care. Every man has a legal right not to be harmed; but is there, apart from a contract, a legal right to be healed? It is no doubt the professional duty of a medical practitioner to treat his patient with due care and skill, but does he, merely by undertaking a case, become subject to a legal duty, a breach of which founds an action for damages, to take due and proper steps to heal the patient?

The court raised this question in a case where the plaintiff alleged, not that he had suffered personal injury or harm as a result of the doctor's negligence, but that he had suffered pecuniary loss — in the form of a loss of earnings — as a result of the delay in the treatment of the injury which he had sustained. The court held that although it was an interesting question, in the circumstances of the case it was unnecessary to decide it.

It is submitted that 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, unless the doctor has expressly guaranteed that the patient will be healed by his treatment — something which the prudent doctor will undoubtedly not generally do! See *Behrmann v Klugman* 1988 (4) SA Practice Management 6 (W); *Chalk v Fassler* 1955 WLD, unreported, and see also our comments above.

In view of the fact that there is no general duty upon a physician to provide medical treatment, the next question we want to discuss is whether it can be said that a physician has a general right to provide treatment.

5.1.2 A professional right to heal?

The question of the precise legal ground or grounds on which medical treatment is based, has been debated extensively, and jurists are not in agreement about this matter. The question is also not merely a theoretical one. To what extent a physician may act in his treatment of a patient may depend on the legal ground on which the medical intervention is based. It is generally accepted that consent will justify medical treatment. But the question of the legal basis of medical treatment is of great importance precisely where it concerns treatment or an operation against the will of the patient, or where the patient is incapable of expressing his will at all.

Instead of consent, the following grounds of justification have been suggested: recognition by the state of the intention to cure; a customary right, and a “professional right”. The notion of a professional right is unpopular, however, in view of the possible implication that the physician would, as it were, be licensed to intervene at any time against the will of the patient. The law of most Western democracies is, however, so individualistic in spirit that the decision whether he wants to be cured or not, is left to the patient. Therefore, justification for medical treatment is still fundamentally to be sought in the patient's consent. South African law has adopted this view too. See *Strauss & Strydom* 178, and the authorities cited there. The important judgment in *Castell v De Greef* 1994 (4) SA 408 (C) on informed consent underlined the patient's right to self-determination or autonomy. This viewpoint was reaffirmed by constitutional recognition of the right to security

in and control over one's body (s 12(2)(b) of the Constitution of the Republic of South Africa, 1996), and the right to privacy (s 14).

Consent as a general prerequisite to medical treatment has been emphasised by the common law since time immemorial. In recent years the South African legislature has touched upon aspects of consent in several statutes, such as the legislation on abortion, sterilisation, the treatment of mental patients and human tissue donation. The most important legislation on informed consent is now to be found in the National Health Act 61 of 2003, to which full reference will be made below.

In *Stoffberg v Elliot* 1923 CPD 148, the judge instructed the jury in the following terms:

In the eyes of the law every person has certain absolute rights which the law protects. They are not dependent on statute or upon contract, but they are rights to be respected, and one of the rights is absolute security to the person Any bodily interference with or restraint of a man's person which is not justified in law, or excused or consented to, is a wrong

Compare the *dictum* in the well-known American case, *Pratt v Davis* 118 Ill App 161 (1905):

Under a free government, at least, the free citizen's first and greatest right, which underlies all others — the right to the inviolability of his person; in other words the right to himself — is the subject of universal acquiescence, and this right necessarily forbids a physician to examine, diagnose, advise and prescribe ..., to violate, without permission the bodily integrity of his patient by a major or capital operation, placing him under an anaesthetic for that purpose, and operating upon him without his consent or knowledge.

A clear distinction must be drawn between a medical intervention **without the patient's consent** (eg emergency surgery being performed on an unconscious victim of a road accident), and a medical intervention **against the patient's will** (eg performance of a blood transfusion on a patient who has positively expressed himself against undergoing the proposed blood transfusion). Assuming that legal justification for the medical intervention is basically to be found in the patient's consent, it must of course not be concluded that every operation performed **without the patient's consent** is invariably unlawful. Should treatment be undertaken without the consent of the patient, for example where he is mentally ill or temporarily incapable of volition (unconscious or under the influence of drugs, etc) the intervention may be legally justified on other grounds. But where the operation or treatment takes place **against the will** of the patient, it will in principle be unlawful. In the American case *Meek v City of Loveland* 85 Colo 346 (1929) a patient was forcibly removed to hospital by the police who had wounded him in his leg after they had mistaken him for a burglar. The "city physician" amputated the patient's leg despite his own and his mother's protests; they insisted that his own doctor be called. On appeal the court held that the physician would be liable if proof of negligence were furnished. In *Woodson v Huey* 261 P 2d 199 (1953), another American case, a spinal anaesthetic was administered to a

patient contrary to her explicit instructions, in consequence of which she was paralysed. She successfully sued the anaesthetist for damages on the ground of “technical assault”. (These judgments were delivered in civil cases, but the same principles are valid in criminal law.)

A medical intervention against the will of a patient will be legally justifiable only where the interests of the state or of society are involved, for example vaccination in order to prevent the spreading of an infectious disease. (See section 33(1)(j) of the Health Act 63 of 1977, and GN R2438, GG 11014 of 30 October 1987, reg 13.) The regulations promulgated in Government Notice R2438 of 30 October 1987 in terms of sections 32, 33 and 34 of the Health Act 63 of 1977, make it possible for medical officers of health to require persons suspected, on reasonable grounds, of being carriers of communicable diseases (such as AIDS) to undergo a medical examination, to be hospitalised or removed to another place of isolation, and to submit to treatment. These regulations might be challenged on constitutional grounds.

It is submitted that in the absence of an overriding social interest such as immunisation of patients in order to protect the community against a threatening epidemic, a doctor is not entitled to treat a patient against his will. It is immaterial whether the patient objects to treatment upon religious grounds (eg refusal to allow a blood transfusion — see *Phillips v De Klerk* 1983 TPD, unreported; the case is discussed by Strauss 29–30) or for any other reason (eg refusal of a cancer patient to submit to chemotherapy because of the fear of possible unpleasant side-effects). The doctor should respect the patient’s refusal, unless it is clear that the latter, on account of shock or confusion of mind, is incapable of rationally expressing his will, in which case the principles relating to emergency treatment will apply.

It is to be noted that in recent decades a document known as the “Living Will” has been made available by the South African Living Will Society to persons who wish to formally register the wish not to be given medical treatment in the event of a terminal illness, if life can only be sustained by artificial means. It is submitted that, provided the signatory is of sound mind, this document should be respected by doctors and medical personnel. But in view of the decision in *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D), an advance directive of this kind will probably be given legal recognition only in extreme cases where the patient is already moribund. (The case is discussed below.) In *Clarke* the court was not prepared to give absolute recognition to a patient’s right of personal autonomy. The validity of the court’s finding in this respect may well sooner or later be constitutionally challenged.

Assuming that the doctrine of consent to injury lies at the root of medical treatment, the question arises whether in this context one can speak of “injury” at all. After all, the aim of medical treatment is not injury, but the very opposite, namely healing the sick, relieving pain, and so on. Can it be said that a successful operation constitutes “violence” or “force”, which is an essential element of assault? It is submitted that this question is to be answered in the affirmative. As Smith (260) pointed out a long time ago:

Surgery is a violent act; its disciples assail disease by force and direct

attack in order to extirpate or alter an abnormal bodily condition. No matter how skillfully done, the breaking of bodily continuity is attended by risk, even so-called minor surgery

If the opposite view were to be held, namely that a successful operation does not amount to bodily “violence” or “force”, consent would be totally irrelevant. Surely, if such an operation could not be considered to conform to the definition of conduct constituting the crime of assault, it becomes irrelevant to inquire whether the actor’s conduct is unlawful. The result would be that a surgeon who forcibly straps an unwilling patient to his operating table and performs a brilliantly successful operation on him, could never be held to have committed an unlawful act because his conduct does not constitute “violence” or “force”. The proper view, we submit, is that any operation must be considered as “violence” or “force”, which will constitute an assault unless consent is proved. In so far as consent excludes liability in respect of medical treatment, it must be considered as a ground of justification, according to the technical meaning of that term.

From what has preceded it follows that the word “injury”, when employed in the doctrine of consent to injury, has a peculiar meaning which is different from its every-day meaning. If an operation takes place against the will of the patient, then he has in fact been injured juridically. At the very least — arguably — his privacy has been violated. The medical operation, if regarded objectively, may be of great advantage to him in that it heals his complaint or saves his life. Thus the administering of a purgative without the patient’s consent can constitute assault or *crimen iniuria*. See *S v Marx* 1962 (1) SA 848 (N); Strydom MJ “*Staat v. Marx*, 1962 (1) SA 848 (N).” 1962 *THRHR* 214. See also our comments on *Broude’s* case (1998) in par 5.3 below.

Force-feeding of hunger-striking prisoners or detainees is a controversial issue. According to the World Medical Association’s Tokyo Declaration of 1975, a doctor should not be involved in the artificial feeding of a prisoner who is “capable of forming an unimpaired and rational judgment”. In its 1991 declaration on hunger-strikers (the “Malta Declaration”) the World Medical Association (WMA) dealt in detail with the conflicting interests raised by hunger-striking. The WMA stated that it is the duty of the doctor to respect the autonomy which the patient has over his person. “A doctor requires informed consent from his patients before applying any of his skills to assist them, unless emergency circumstances have arisen in which the doctor has to act in what is perceived to be the patient’s best interest.” A special conflict of values arises where a hunger-striker who has issued clear instructions not to be resuscitated lapses in a coma and is about to die. The WMA is of the opinion that the ultimate decision of intervention or non-intervention should be left to the individual doctor. The doctor should clearly state to the patient whether or not he is able to accept the patient’s decision to refuse treatment, or in a case of coma, artificial feeding. If the doctor cannot accept the patient’s decision to refuse such aid, the patient will be entitled to be attended by another doctor. Subject to this restraint, the doctor is free to make a decision on further treatment in the case of a patient who has become confused or comatose.

In March 2000 the High Court of England refused to interfere with medical

force-feeding of a notorious prisoner, Brady, known as the Moors Murderer. It was held that his severe personality disorder had resulted in incapacity to decide the issue. (He wanted to starve himself to death and had embarked on a hunger strike.)

It is the policy of the South African prison authorities not to force-feed hunger-strikers. However, once a hunger-striker becomes comatose, a doctor will be entitled for humanitarian reasons to provide medical treatment to him, including intravenous feeding. In our opinion a doctor will likewise be entitled to give medical treatment to a person who has attempted to commit suicide. See Strauss at 409–414. (The validity of our view may well sooner or later be challenged on constitutional grounds.)

5.1.3 Consent to injury: general criteria

The defence of consent to injury is of course relevant not only in the assessment of the lawfulness or unlawfulness of medical treatment; it can be raised in a variety of other situations. This defence is expressed in the well-known maxim, *volenti non fit iniuria*, which can be translated as “no injustice is done to him who is willing”. This principle is an expression of the individualism which is peculiar to a society in which the freedom of the individual enjoys the highest respect. Each individual is considered to be free to work out his own salvation. Whilst the individual is protected against a violation of his interests by other persons, the law does not protect him against actions resulting from personality traits or his own voluntary acts or lack of care. Although the *volenti* maxim might appear to be of general applicability, it is subject to important reservations and restrictions.

The Romans considered violation of a person’s interests with his consent to be fundamentally lawful, except in certain special instances. On the other hand, in Roman-Dutch law bodily violation was in principle an unlawful act, except in special instances. On Roman and Roman-Dutch law, see 1964 *SALJ* 179–180.

Whether consent would constitute a defence in modern criminal law or the law of delict would depend on whether the actor’s conduct is assessed to be *contra bonos mores*. See Neethling et al 94. An act will accordingly be judged unlawful if consent to the act is regarded to be in conflict with good morals. See *Boshoff v Boshoff* 1987 (2) SA 694 (O). “Good morals” in this context do not refer to morality as such. One should rather understand the term as signifying the prevailing attitudes of society concerning what kind of conduct is lawful and what kind unlawful. In this sense the notion of good morals constitutes a **juristic criterion**. The same viewpoint was adopted in Roman and in Roman-Dutch law regarding the *boni mores* as a standard for the assessment of unlawfulness or wrongfulness. The term *boni mores* therefore refers to the juristic attitudes (*regsopvattinge*) of society. See Joubert *WA Grondslae van die persoonlikheidsreg* (1953) 109, 128 and 146; *Universiteit van Pretoria v Tommie Meyer Films (Edms) Bpk* 1977 (4) SA 376 (T); *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D).

So much for the general criteria regarding the validity of consent. In a subsequent section these criteria will be related to specific medical procedures.

5.2 The concept of consent

5.2.1 General

Whether there was consent or not in a particular instance is a question of fact. The manner in which the manifestation of the will occurred is of little importance in substantive law. The law prescribes no definite form save in exceptional instances. Proof of consent occurs where the conduct of the patient, in the light of all the surrounding circumstances, was such that one could reasonably infer from it the mental attitude of acquiescence to or satisfaction with the proposed treatment.

The patient can consent expressly to the operation or treatment, that is he can consent in words, either orally or in writing. Although consent in writing facilitates subsequent proof and is most desirable in the case of serious procedures, it would be impractical for the physician to obtain written consent from the patient with each treatment. Nor need the patient declare in so many words that he consents to a particular medical procedure. Consent generally takes place by way of a request made by the patient for a specific form of treatment or an operation. It takes place just as often by mere tacit submission to the treatment.

In our law, however, as in English and American law, there is a distinction between mere submission and consent. In *Stoffberg v Elliot* 1923 CPD 148, Watermeyer J seems to have required express consent in medical operations, but this proposition cannot be upheld. It is generally accepted that consent can be either express or implied. When a person who is capable of manifesting his will submits himself to an operation in full knowledge of the nature of the operation, and his unwillingness does not manifest itself in any form of resistance, protest or attempt at escape, or anger, etcetera, no other reasonable inference can be drawn save that he consents to the operation. The more drastic the nature of the medical treatment, the more definitely ought the physician to ensure, for the sake of his own protection, that express consent is obtained from the patient.

Words in themselves do not always truly reflect the meaning of the speaker's thoughts. Human beings frequently present a facade behind which they conceal their true feelings. Where the patient, by conduct, in words or in any other form, manifests an apparent willingness, or acquiescence to, or reconciliation with the prospect of undergoing a surgical operation, but in fact conceals a *reservatio mentalis* behind this, his apparent consent will legally be taken as true consent. See *Boshoff v Boshoff* 1987 (2) SA 694 (O).

The situation might present itself where the patient expressly declares, from fear of pain or some other injurious consequence, that he does not wish to undergo the treatment, but submits to it nevertheless. In such instance, where the tacit conduct betokens an attitude different from that contained in the spoken words, it is the former which must settle the matter. General human experience shows that tacit conduct in such an instance is a more reliable indication of the patient's attitude than his words are. Deeds say more than words.

Submission without consent, which was mentioned above, is of real importance in the case of minors, however. An illuminating case from

English law is *R v Case* 1 Den 580. In the course of treatment a doctor had intercourse with the complainant, a girl aged fourteen, on the pretext that this comprised part of the treatment. Under a misconception that this was in fact so, the girl submitted. On behalf of the accused it was argued that she had consented because there had been no resistance on her part. “That”, declared the judge, “is a fallacy. Children who go to a dentist make no resistance; but they are not consenting parties.” The doctor’s defence was rejected and he was found guilty of assault. It goes without saying that one cannot conclude from the *dictum* quoted that medical treatment of a minor can occur only with the compliance of the minor. In the majority of cases consent by the parent or guardian of a child will be sufficient, and the child’s opposition irrelevant.

Where a patient has consented to a specific operation — even if his consent was given orally and not in writing — the doctor should not perform another operation or go beyond the procedure agreed upon. See *Pop v Revelas* 1999 WLD (unreported). In this case the patient consented to have a patch of thickened skin (a callosity) from his foot removed. When the doctor operated on the patient a few days later, however, he went right into the foot to where the tendons are and cut off the parts of the body which cause the toes to move. The court held that there was no consent to the latter procedure and that the operation constituted assault. (What makes this case particularly interesting is the fact that when the patient was admitted to the hospital for the operation, he signed the hospital consent form on which the more extensive procedure was described. The doctor relied on the consent form as a defence. The court held, however, that the latter was a document between the patient and the hospital. It was not a contract between the patient and the doctor. Of importance is to note that the doctor had not countersigned the consent form, although his name was entered on it by the hospital staff as the operating doctor.)

On consent in general see Strauss 3–13, and Van Oosten FFW *The doctrine of informed consent in medical law* (1991).

5.2.1.1 *Substituted consent*

As we have mentioned under 5.1.2 above, the informed consent of the patient is in principle required both by common law and by virtue of the provisions of the National Health Act 61 of 2003.

The basic point of departure in terms of section 7 is that, barring certain exceptions, a health service may not be provided to a user without the user’s informed consent. Section 7 of the Act, however, makes provision in general terms for substituted consent as follows:

- Where the patient is unable to consent, consent may be given by a person mandated by the patient in writing to grant consent on his or her behalf, or by a person authorised to give consent in terms of any law or court order (s 7(1)(a)).
- Where the patient is unable to consent and no person is mandated or authorised to give consent, consent may be given by the patient’s spouse or

partner, or in the absence of a spouse or partner, a parent, grandparent, an adult child or a brother or sister of the patient, in the specific order as listed (s 7(1)(b)).

Note that, in terms of section 8(2)(a), where consent is given by someone other than the patient, that person must, if possible, first consult the patient. A patient who is capable of understanding must be informed of the matters referred to in section 6 of the Act — see below — even if he or she lacks the capacity to give the informed consent required by section 7 (see s 8(2)(a)). For purposes of section 7, “informed consent” is defined as consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6 (see s 7(3)). If the patient is unable to participate in a decision affecting his or her personal health and treatment, he or she must be informed of the relevant matters after treatment, unless the disclosure of such information would be contrary to the patient’s best interests (s 8(3)).

5.2.1.2 *Treatment without consent*

As we shall see below, the common law makes provision for emergency treatment without consent.

The National Health Act 63 of 2003, section 7, also makes provision for treatment without consent in situations of dire emergency. Thus, section 7(1)(e) provides that a health service may be provided to a user without his or her informed consent where any delay in the provision of the health service to the user might result in his or her death or irreversible damage to his or her health, and the user has not expressly, impliedly or by conduct refused that service. Section 7(a) and (b) further provide for the provision of health services to a user without his or her consent where:

- the provision of the health service without informed consent is authorised in terms of any law or a court order
- failure to treat the user might result in a serious risk to public health

The provisions of section 8 obliging health personnel to inform the unconsenting patient **after** treatment (mentioned in section 5.2.1.1 above, also apply here).

The National Health Act, section 9, governs hospitalisation of a patient without consent. If that happens the hospital (or other health establishment) must notify the head of the provincial health department within 48 hours, unless the 48-hour-period expires on a Saturday, Sunday or public holiday, when a slightly more lenient arrangement applies. The duty to notify does not apply, though, if the patient consents within 24 hours.

5.2.2 *Minors*

In the case of a minor, consent on the part of a parent or guardian will, in principle, be required (see *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T)). The minor is, after all, subject to parental authority.

It is to be noted that a parent may by common law delegate various incidents of his parental authority to a person who acts *in loco parentis*, such as a

teacher, a youth leader or a relative who may be caring for the child temporarily. Where a parent has expressly or tacitly authorised such a person to consent to medical treatment on his behalf, that person may lawfully do so (see Boberg PQR *The law of persons and family* (1977) 316 n 9).

Problems may arise when the child is in need of an operation or medical treatment, but the parents refuse consent on religious or other grounds. However, section 39(1) of the Child Care Act 74 of 1983 offers a solution. The subsection provides that where a doctor is of the opinion that it is necessary to perform the operation or submit the child to treatment, and the parent or guardian refuses consent, the doctor must report the matter to the Minister, who may then consent in lieu of the parent or guardian. The same provision applies where the parent cannot be found, or is by reason of mental illness unable to consent, or is deceased. (The Minister has delegated her power to certain officials.) Significantly the Child Care Act declares the parent or guardian liable for the costs of the medical treatment involved (s 39(3)).

The Child Care Act also makes provision for consent by the medical superintendent of a hospital in emergencies, without consulting the person legally competent to consent on behalf of a child (such as the child's parent or guardian) (s 39(2)). The superintendent must satisfy himself on two points: first, that the operation (or treatment) is necessary to preserve the life of the child, or to save him from serious and lasting physical injury or disability; second, that the treatment indicated is so urgent that it ought not to be deferred for the purpose of consulting the person legally competent to consent on behalf of the child. The parent or guardian is liable for the costs of the operation or treatment thus authorised.

Cases of absolute emergency may occur where it would be altogether impracticable or dangerous to defer action in order to request the medical superintendent or other official to give consent. An example would be cardiac arrest where cardiopulmonary resuscitation (CPR) must be resorted to without any delay. Without a doubt the doctor, nurse or paramedic can take immediate action without first seeking consent or official authorisation of any kind. In such a case the rescuer can rely on the common-law doctrine of *negotiorum gestio*.

The Child Care Act further vests the management of institutions (such as reform schools, industrial schools and children's homes) with the power to authorise medical operations on, or treatment of, children who are inmates (s 53(1)). The same criteria apply as in the case of medical superintendents (see s 53(4)). It is to be noted, however, that where the operation or treatment is not of such an urgent kind, the head of the institution must first consult the parent or guardian, or the Minister. The Child Care Act specifically provides that the powers of the management of an institution do not include the power to consent to medical treatment or operations attended by serious danger to life (s 53(3)).

What has been said in the preceding paragraph is of equal application to persons in whose custody a child has formally been placed under the Child Care Act 74 of 1983 (s 53(1)) or the Criminal Procedure Act 51 of 1977 (s 290).

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

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

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

In these cases **section 39(4) of the Child Care Act 74 of 1983 makes it possible for a minor who is 18 years or older to independently consent to a medical operation, and a child who is 14 years or older, to medical treatment.** The Legislature has refrained from endeavouring to define "medical operation" or "medical treatment". Each case is therefore considered on its own merits. If a dispute were to arise, the courts would have to decide on the basis of expert medical evidence where the dividing line between an "operation" and "treatment" lies. It is submitted that the courts will apply a common-sense approach. "Operation" will probably be confined to substantial surgical interventions and not to procedures such as the extraction of a tooth or the draining of an abscess.

"Medical treatment" decidedly includes birth-control measures provided by a medical practitioner, such as the insertion of an intra-uterine device or the

prescribing of an oral contraceptive. A girl who is 14 years or older will therefore be able to consent independently to such measures.

A strict interpretation of the Child Care Act appears to lead to the conclusion that in the case of a minor below the age of 14 years, a parent or guardian's consent is required. But in England it was held that where contraception is provided to a minor female in good faith by a clinic or doctor without consultation with the parents, a court will not readily intervene (see *Gillick v West Norfolk and Wisbech Area Health Authority and Another* [1985] 3 All ER 402 (HL)). (It is to be noted, though, that the English statutory provision relating to the age of medical consent [which is 16 years] is worded somewhat differently than the South African provision.)

Our Legislature has wisely ordained (also in s 39(4)) that a minor who is 14 years or older may also consent to the **medical treatment** of his or her own child. This has resolved the difficulty which arose after the promulgation of the Children's Status Act 82 of 1987 (s 3(1)(a)) which laid down that where an unmarried minor female has an illegitimate child, her (the mother's) guardian shall be vested with the guardianship of the illegitimate child. The result was that the young unmarried mother could not give consent to the medical treatment of her own child.

It is to be noted that although a child is statutorily given the right to consent independently, this does not mean that a child can refuse medical treatment which the parent has requested and consented to. The authority which a parent legally has over the child will entitle the parent to compel a minor child to undergo medical treatment or an operation, provided that it is, objectively seen, in the interests of the child.

In regard to abortion, however, other principles apply. As we shall see below, a minor female may in terms of the Choice of Termination of Pregnancy Act 92 of 1996 consent independently to abortion. No age limit is prescribed by the Act. We submit, however, that the intellectual maturity of the girl should be such as to enable her to appreciate the nature of the intervention. In *G v Superintendent, Grootte Schuur and Others* 1993 (2) SA 255 (C) the court refused to grant a mother's application to prevent an abortion from being lawfully performed on her 14-year-old daughter who had been raped.

It is doubtful whether a court would be prepared to grant an application brought by the parents of a girl who is capable of exercising her will, to force the girl to undergo a lawful abortion against her will. (Our courts have already refused to order that an illegal abortion be performed against the will of a pregnant girl. See Strauss 212.)

There are also special provisions relating to consent to sterilisation of minors, which we discuss below.

In addition to the common-law principles and the provisions of the Child Care Act, the provisions of the National Health Act 61 of 2003 on substituted consent (which we discussed in section 5.2.1.1 above) may also be relied upon in certain cases involving medical treatment of minors.

Finally, mention must be made of section 335B of the Criminal Procedure Act 51 of 1977. This section governs medical examination upon the initiative of a police official of a minor who has been the victim of a sexual offence or an

offence of a violent nature, where the parent or guardian (a) cannot be traced within a reasonable time; (b) cannot grant consent in time; (c) is a suspect in respect of the offence in consequence of which the examination must be conducted; (d) unreasonably refuses to consent that the examination be conducted; (e) is incompetent on account of mental disorder to consent that the examination be conducted; or (f) is deceased. A magistrate must then be approached for consent. If a magistrate is not available, certain senior police officers may give consent, subject to certain procedural requirements.

(Please note that the Children's Act 38 of 2005 envisages the repeal of the Child Care Act 74 of 1983 once it takes effect.)

5.2.3 Mental patients

5.2.3.1 General

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

In the case of a minor patient who is mentally unable to consent, a parent or guardian may by common law give the necessary consent. As far as a major patient who is incapable of consenting is concerned, the personal curator could, in common law, consent. This was confirmed in *Ex parte Dixie* 1950 (4) SA 748 (W), where the doctors had recommended a leucotomy (a type of brain operation that can result in behaviour modification). The court ruled, in general terms, that a non-emergency operation cannot lawfully be performed without the consent of the patient. If he is not competent to give it, consent must be given by "some person in authority over his person". "The fact that he is a patient in a hospital," the court ruled, "does not entitle those in charge of it to perform any surgical operation upon him which they may consider beneficial." A curator for the person of the patient was accordingly appointed by the court to consider whether an operation was to be performed and to consent thereto if it was so decided.

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

What about the patient who is in private care and has neither a curator nor relatives, or who has been deserted by his relatives? It is suggested that to obviate the necessity of an application to court for a special curator to be appointed, the legislature should make provision for the superintendent of

the hospital in which the operation will be performed or treatment will be given, to give consent in special circumstances (similar to the power given by s 39(2) of the Child Care Act 74 of 1983 to medical superintendents).

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

It is necessary here to refer also to frail, aged persons who are not necessarily diagnosable with mental illness, but on account of old age are incapable of controlling their lives independently and are being cared for by relatives. It is a daily occurrence that medical treatment is administered and even medical operations performed on such persons by doctors after consultation with relatives. In our opinion a common-law principle has evolved in terms of which the consent given by such caring relatives is sufficient to justify medical intervention.

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

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

The provisions of the National Health Act 61 of 2003 on substituted consent, which we discussed above in section 5.2.1.1, may be relied upon in some situations involving non-emergency medical treatment of mentally ill persons, but do not cover the type of situations where no spouse or relatives can be traced.

5.2.3.2 The Mental Health Care Act 17 of 2002

The Mental Health Care Act 17 of 2002, which took effect on 15 December 2004, contains a number of sections relating to aspects of consent to the treatment of a mentally ill person. This Act repealed the Mental Health Act 10 of 1978 (except for ch 8 thereof). Accordingly, section 60A of the old Mental Health Act 10 of 1978, which made provision for substituted consent on behalf of a mental patient, was also repealed by the Act.

The Act differentiates between “voluntary”, “assisted” and “involuntary” care, treatment and rehabilitation (hereinafter referred to as “interventions”) (see s 1). “**Voluntary** care, treatment and rehabilitation” means the provision of health interventions to a person **who gives consent** to such interventions. “**Assisted** care, treatment and rehabilitation” means the provision of health interventions to people **incapable of making informed decisions** due to their mental health status **and who do not refuse** the health interventions. “**Involuntary** care, treatment and rehabilitation” means the provision of health interventions to people **incapable of making informed decisions** due to their mental health status **and who refuse health intervention** but require such services for their own protection or for the protection of others.

Section 9(1) provides that a health care provider or a health establishment

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

A person or health establishment that provides care, treatment and rehabilitation services to a mental health care user or admits the user in the circumstances referred to in subsection (1)(c), must report this in writing to the relevant Review Board, and may not continue to provide such care, treatment and rehabilitation services for longer than 24-hours unless an application in terms of chapter V of the Act is made within the 24-hour period (see s 9(2) of the Act). Chapter V provides for application to be made for assisted and involuntary care, treatment and rehabilitation services.

A Review Board must be established in respect of every health establishment providing mental health care, treatment and rehabilitation services in that province (s 18). Review Boards bear responsibility, *inter alia*, for making decisions with regard to assisted or involuntary interventions, considering reviews and making decisions on assisted or involuntary mental health care users, and considering 72-hours assessments made by the head of the health establishment, and making decisions to provide further involuntary interventions (see s 19).

(a) Assisted care, treatment and rehabilitation

Section 26 provides that, subject to section 9(1)(c), a mental health care user may not be provided with **assisted** care, treatment and rehabilitation services at a health establishment as an **outpatient or inpatient** without his or her consent, unless

- (a) a written application for the intervention is made to the head of the health establishment concerned and he or she approves it; and
- (b) at the time of making the application
 - (i) there is a reasonable belief that the mental health care user is suffering from a mental illness or severe or profound mental disability, and requires intervention for his or her health or safety, or for the health and safety of other people; and
 - (ii) the mental health care user is incapable of making an informed decision on the need for the intervention.

In terms of section 27(1)(a), the written application referred to in section 26 may only be made by the spouse, next of kin, partner, associate, parent or guardian of a mental health care user, but where the

- (i) user is below the age of 18 years on the date of the application, the application must be made by the parent or guardian of the user; or
- (ii) spouse, next of kin, partner, associate, parent or guardian of the user is unwilling, incapable or not available to make such an application, the application may be made by a health care provider.

The head of the health establishment must, upon receipt of the application, ensure that the mental health care user is examined by two mental health care practitioners (none of which may be the applicant) — section 27(4). They have to provide the findings of their examination in writing to the head of the health establishment on whether the circumstances in section 26(b) are applicable and whether the mental health care user should receive the intervention as an inpatient or outpatient. Should the report of these two differ, another mental health care practitioner must examine the user and report his or her findings as set out above — section 27(6). The head of the health establishment may only approve the application if the findings of two of the mental health care practitioners concur that conditions for assisted intervention exist — section 27(7). The head of the health establishment may only approve assisted intervention as an **inpatient** if

- (a) the findings of two mental health care practitioners concur that conditions for inpatient intervention exist; and
- (b) he or she is satisfied that the restrictions and intrusions on the rights of the mental health care user to movement, privacy and dignity are proportionate to the intervention required.

In terms of section 27(9), the head of the health establishment must give written notice to the applicant of his or her decision concerning the intervention to the applicant, and must give reasons for the decision.

The head of the health establishment must send a copy of the application together with a confirmation of his or her decision to the relevant Review Board within seven days of his or her decision — section 28(1).

The Review Board must, within 30 days of receipt of the documents referred to in the preceding paragraph, conduct an investigation into the

- (a) incapacity of the mental health care user to make an informed decision on the need for the assisted intervention; and
- (b) circumstances under which the mental health care user is receiving the intervention, whereupon they must request the head of the health establishment either to continue providing the mental health care user with the appropriate care, treatment and rehabilitation services, or discharge him or her according to accepted clinical practice — section 28(2) and (3).

Note that provision is also made in section 29 for appeal against the decision of the head of the health establishment, and in section 30 for periodic review of the assisted mental health care user's mental health status six months after commencement of assisted intervention, and every 12 months thereafter. Section 31 contains certain provisions pertaining to assisted mental health care users who have recovered their capacity to make informed decisions.

(b) Involuntary care, treatment and rehabilitation

What is the position of a person who refuses intervention? Section 32 stipulates that a mental health care user must be provided with intervention without his or her consent at a health establishment on an **outpatient or inpatient** basis if

- (a) an application in writing is made to the head of the health establishment concerned to obtain the necessary intervention and the application is granted;
- (b) at the time of making the application, there is reasonable belief that the mental health care user has a mental illness of such a nature that
 - (i) the user is likely to inflict serious harm to himself or herself or others; or
 - (ii) the intervention is necessary for the protection of the financial interests or reputation of the user; and
- (c) at the time of the application the mental health care user is incapable of making an informed decision on the need for the intervention and is **unwilling** to receive the intervention required.

The persons who may make the application for involuntary care are listed in section 33(1)(a) and are the same as those who may make the application for assisted care (listed in s 27(1)(a) set out above).

Just as in the case of assisted intervention, the head of the health establishment must, upon receipt of the application, ensure that the mental health care user is examined by two mental health care practitioners (none of which may be the applicant) — section 33(4). They have to provide the findings of their examination in writing to the head of the health establishment on whether the circumstances in section 32(b) and (c) are applicable and whether the mental health care user must receive involuntary care, treatment and rehabilitation. Should the report of these two differ, another mental health care practitioner must examine the user and report his or her findings as set out above — section 33(6). The head of the health establishment may only approve the application if the findings of two of the mental health care practitioners concur that conditions for involuntary intervention exist — section 33(7). In terms of section 33(8), the head of the health establishment must, in writing, inform the applicant of his or her decision on the application to provide involuntary care, treatment and rehabilitation services. He or she must also provide reasons for the decision.

If the head of the health establishment approves involuntary care, treatment and rehabilitation services, he or she must within 48 hours cause the mental health care user to be admitted to that establishment, or refer the user to any other health establishment with appropriate facilities (s 33(9)).

If the approval is given, a doctor and another mental health care practitioner must assess the physical and mental status of the patient for a 72-hour period in order to establish whether involuntary care, treatment and rehabilitation services are justified (s 34(1)). These two health practitioners must consider whether the involuntary services must be continued and, if so, whether on an outpatient or inpatient basis.

Following the assessment, the head of the health establishment must do certain things, depending on the opinion to which he or she has come:

- (a) If the head is of the opinion that the user's mental health status does not warrant involuntary services, the user must be discharged immediately, unless he or she consent to the services;

- (b) If the head is of the opinion that further involuntary services are warranted on an outpatient basis, he or she must
 - (i) discharge the user subject to the prescribed conditions or procedures relating to his or her outpatient care, treatment and rehabilitation services; and
 - (ii) inform the Review Board in writing.
- (c) If the head is of the opinion that further involuntary services are warranted on an inpatient basis, he or she must request the Review Board in writing within 7 days after the expiry of the 72-hour assessment period to approve such further involuntary services. Certain documents have to be attached and the applicant has to be informed.

If at any time after the expiry of the 72-hour assessment period, the head is of the opinion that the involuntary user who was admitted on an inpatient basis is fit to be an outpatient, he or she must discharge the user and inform the Review Board (s 34(5)).

Note that provision is made in section 35 for appeal against the decision of the head of the health establishment, in section 36 for judicial review on the need for further involuntary services, and in section 37 for periodic review of the involuntary mental health care user's mental health status six months after commencement of involuntary services, and every 12 months thereafter. Section 38 contains certain provisions pertaining to involuntary mental health care users who have recovered their capacity to make informed decisions.

5.2.4 Spouses

Spouses can consent independently to any type of medical intervention, even interventions affecting procreation, such as contraception, sterilisation or abortion, and even if they are married in community of property. This principle applies even where a spouse undergoes a sterilisation purely for convenience and in the absence of a medical indication (see our discussion of sterilisation below). The consent of a married woman's husband is not a requirement for artificial insemination, but in the absence of the husband's consent, the child born as a result of such artificial insemination may not be regarded as the legitimate child of the husband (see the Children's Status Act 82 of 1987).

A husband has no right to force his wife to undergo an operation against her will or even to submit to medical examination (*Palmer v Palmer* 1955 (3) SA 56 (O)).

With regard to spouses we should mention a situation that occurs in practice quite often: a husband or wife is seriously ill or injured and perhaps semi-conscious. The attending doctor will consult with the other spouse about the necessary medical intervention and the latter will then give consent, often by signing a consent form. We submit that this "common sense" situation has become a common-law rule, and that the doctor will not incur any liability in respect of the medical procedure performed in these circumstances without the express consent of the ailing spouse.

As we have seen above, the National Health Act 61 of 2003 provides that if a

person is unable to consent to a medical intervention, his or her spouse may consent on his or her behalf (s 7).

5.3 The doctor's duty to inform the patient

5.3.1 General requirements

To be legally valid, consent must be based on substantial knowledge concerning the nature of the act consented to. It must, in other words, be an "informed" consent. Because of the technical nature of most forms of medical treatment and surgical operations, there is a duty upon the doctor to inform the patient. During the past three or four decades a major debate has raged internationally regarding the criterion (or criteria) for the amount of information that a doctor must convey to his or her patient concerning the diagnosis and in particular the risks attendant upon the proposed treatment or operation. By the turn of the century this issue had not yet been conclusively decided by the courts of South Africa.

Although there is no need for the doctor to meticulously point out all the conceivable complications that may arise (*Lymbery v Jefferies* 1925 AD 326) the patient should at least be informed of the **serious risks** involved in the operation, for example that it may be necessary to amputate his penis (*Stoffberg v Elliot* 1923 CPD 148), that fractures of his pelvis may result from electroshock therapy (*Rompel v Botha* 1953 TPD unreported, quoted in *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T)) or that disfigurement, cosmetic changes and necrosis resulting in the necessity to amputate limbs, may flow from radiological treatment for cancer (*Esterhuizen's* case). Where the risk of a particular form of treatment is **extremely uncommon**, for example partial paralysis flowing from an injection known as a phenol block of the lower sacral nerves (*Richter and Another v Estate Hamman* 1976 (3) SA 226 (C)) the doctor cannot be held liable for failure to mention such possibility to the patient.

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

In the *Richter* case the court intimated that, in principle, a doctor's conduct in informing a patient should be tested by the standard of the reasonable doctor faced with a particular problem: "In reaching a conclusion [as to a disclosure

of risks by the doctor] a court should be guided by medical opinion as to what **a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do.**” [Our emphasis.]

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

A risk is material if, in the circumstances of a particular case:

- (1) a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it, or
- (2) the doctor is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it

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

In his judgment in *Castell* Ackermann J was guided by legal developments in North America and Australia and on the European Continent. (As the judge pointed out, England still maintains the older “reasonable doctor” standard, which was reaffirmed in the case of *Sidaway v Bethlem Royal Hospital Governors and others* [1985] 1 ALL ER 635 (HL).)

(The facts of the *Castell* case are discussed briefly below.)

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

Following the operation there were indications that B suffered facial palsy

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

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

The Appeal Court considered it a strange notion that this type of case should be juristically characterised as assault. We respectfully submit, however, that at the very least the doctor in this type of case violated the constitutionally protected right of privacy of the patient, which should entitle the latter to normal damages even though the procedure did not result in physical harm to the patient. Privacy, in our view, embraces amongst other things the right of the patient to be apprised in advance about the material risks involved in a proposed procedure. (The *Broude* case is further discussed below.)

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

The *Castell* "material risk" test was confirmed by the court *a quo* in *Oldwage v Louwrens* [2004] 1 All SA 532 (C). In this case the patient experienced severe pain in his right leg. Having examined him, the defendant, a specialist vascular surgeon, diagnosed his condition as a blockage in his arteries, and later recommended and performed an iliac bi-femoral by-pass operation. However, the patient was still not relieved of the pain and subsequently underwent a laminectomy at the hands of a neurosurgeon. After the latter operation he started experiencing pain in his left leg, and the neurosurgeon established that he suffered claudication (pain caused by poor circulation due to blockage of arteries) in his left leg. The court later found that the defendant had misdiagnosed the patient's condition. Moreover Yekiso J found that the patient had not been properly counselled prior to the operation of other

options regarding treatment or of the material risks (such as claudication as a result of “steal syndrome”) attendant on the proposed operation. There was, accordingly, no proper informed consent, and the surgeon’s conduct constituted assault. The judge emphasised the importance of patient autonomy.

The case went on appeal to the Supreme Court of Appeal, where the appeal was upheld — see *Louwrens v Oldwage* [2006] 1 All SA 197 (SCA). The Supreme Court of Appeal again (see *Broude’s* case above) refrained from giving any unequivocal indication on the correctness of the materiality test applied in *Castell v De Greef* by the full bench. The court merely held that the risk of “steal syndrome” occurring (with the resultant claudication) was so negligible (around two percent) that it was not unreasonable for the defendant not to mention it.

These cases make it clear that the last word on informed consent — in particular on the criterion for the amount of information the patient is to be given — is yet to be spoken. **In our view doctors should in the meantime be guided by the reasonable-patient test as expounded in the well-reasoned *Castell* judgment.**

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. Although doctors will frequently inform the patient of the diagnosis, this is not considered an absolute requirement in law. But where the patient postulates information about the diagnosis as a condition to consent, this should be made known to him.

The duty to inform the patient in essence lies with the doctor, but he or she may delegate it to qualified personnel. Thus, in respect of stomatherapy necessitated by a colostomy, highly trained nurses are employed to perform this task. (Cancer of the colon is commonly treated by surgical removal of part of the colon and creation of a new opening of the colon on the surface of the body; that opening is called a “stoma”, and it requires proper care.)

It is submitted that where it would have a manifestly harmful effect upon the patient to inform him of the diagnosis or of the potential effects of treatment, for example where a cancer patient will most probably become despondent to such an extent that the effectiveness of treatment is endangered, or that he might develop suicidal tendencies, it is not necessary for the doctor to inform the patient (see the remarks in *SA Medical and Dental Council v McLoughlin* 1948 (2) SA 355 (A) at 366 and in *Richter’s* case, supra at 232G). The term “therapeutic privilege” is used in this connection (see Strauss 18). On therapeutic privilege see Welz D “The boundaries of medical-therapeutic privilege” 1999 SALJ 299 and in particular Coetzee LC *Medical therapeutic privilege* LLM dissertation Unisa (2001).

The issue of therapeutic privilege also arose indirectly in *VRM v Health Professions Council of South Africa and Others* (2003 TPD, unreported as yet). A doctor examined a woman pregnant with her first child one month before its birth, and established that she was HIV positive. The doctor did not inform the woman because he considered it “heartless and cruel” to do so; at that stage such information could in his opinion not change anything. The

baby was eventually still-born. A committee of preliminary inquiry of the Council resolved not to refer the matter to a disciplinary committee. The court ruled that in the circumstances of the case there was a duty on the Council to refer the mother's complaint to a disciplinary committee. (In this case the issues surrounding informed consent to HIV testing and counselling of patients also came to the fore.)

Therapeutic privilege is accorded express but limited recognition by section 13(3) of the Mental Health Care Act 17 of 2002: a mental health care provider may temporarily deny a mental health care user access to information contained in his or her health records if disclosure of that information is likely to seriously prejudice the user or cause the user to conduct himself in a manner that may seriously prejudice him or the health of other people.

As Deutsch E *Arztrecht und Arzneimittelrecht* 2 ed (1991) 73 has indicated, over-informing the patient may have the effect of his simply not being able to grasp what he has been told. This situation must be dealt with as if the doctor had not enlightened the patient at all.

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

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

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

Both pre-test and post-test counselling should be carefully documented by the doctor, and a proper written consent should be obtained. The doctor should ensure that the patient be informed in his or her own language.

Concerning HIV testing it should be mentioned that the Employment Equity Act 55 of 1998, section 7(2), prohibits such testing of an employee unless the Labour Court has determined the justification thereof. The legislature's intent with this subsection and its exact scope became subjects of serious debate. See, for example, La Grange MAC “The Employment Equity Act — another HIV calamity” 2000 *SAMJ* 773; Joni J “Another unfortunate interpretation of section 7(2) of the Employment Equity Act” 2000 *SAMJ* 1102.

Note that the “Code of good practice: Key aspects of HIV/AIDS and

employment” published (in GN R1298 GG 21815 of 1 December 2000) under Act 55 of 1998 as well as the Labour Relations Act 66 of 1995, contains *inter alia* directives relating to HIV testing of employees.

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

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

Please also see the decision of the Labour Court in *Ndebele Mining Company (Pty) Ltd — Ex parte* (July 2001).

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

5.3.3 National Health Act 61 of 2003 and informed consent

The provisions of chapter 2 of the National Health Act 61 of 2003 on informed consent in essence largely reinforced the common-law position as set out above. *Inter alia* the doctor is required by section 6 to inform the patient of “the benefits, risks, costs and consequences generally associated with each [treatment] option”. This provision can decidedly not be interpreted as requiring information to be given on all conceivable risks.

The doctor must further inform the patient of the range of diagnostic procedures and treatment options generally available to the patient. Note that section 6(1)(d) requires the doctor to inform the patient also of his or her right to refuse health services and to explain the implications, risks and obligations of such refusal. The doctor must, where possible, inform the patient in a language that the patient understands and in a manner which takes into account the latter’s level of literacy.

Note further that section 6(1)(a) clearly gives statutory recognition to therapeutic privilege in requiring the doctor to inform the patient of his or her health status “except in circumstances where there is substantial evidence that the disclosure of the [patient’s] health status would be contrary to the best interests of the [patient]”.

5.4 Doctor deviating from operation consented to

As a general rule 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, for example where radical radiological treatment is given instead of superficial X-ray treatment agreed upon (*Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T)).

It sometimes happens that the doctor discovers, whilst operating on a patient who has consented to a specific type of operation under general anaesthetic, that another serious condition exists, or another organ or body part is also affected, or the patient’s condition is worse than anticipated. Under such circumstances the doctor may be justified in trying to remedy such condition, provided that:

- (1) such extension of the operation is in accordance with good medicine
- (2) the extension takes place in good faith in order to alleviate the patient’s complaint
- (3) the risk to the patient is not materially increased
- (4) 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

(See Strauss & Strydom 223 *et seq*)

In practice, when a patient consents to a surgical procedure, written consent is commonly given to the surgeon permitting him to extend the procedure should that be regarded as medically necessary. See for example *Fowlie v Wilson* 1993 NPD (unreported). However, the facts of a case may be such that the written consent signed by the patient is no more than a “document between patient and hospital” and does not as such cover the doctor or the procedure performed by him. See *Pop v Revelas* 1999 WLD (unreported) discussed above.

It goes without saying that in cases of emergency, the extension of an operation without the patient’s consent may be justified on the basis of necessity (see next section).

5.5 Medical intervention without consent in emergencies

As we have mentioned above, consent by the patient, or by someone else on his behalf, is not always a requirement for medical treatment. The common-law position regarding emergency treatment of patients without consent was reaffirmed by the National Health Act 2003, section 7(1)(e), which provides that a health service may be provided to a patient without his or her consent if any delay might result in the patient’s **death or irreversible damage to his or**

her health, and the patient has not expressly, impliedly or by conduct refused that service.

Determining the legal ground on which emergency treatment is based is not important from a theoretical point of view only. It may also be of practical significance in order to establish the rights and obligations that exist between doctor and patient. Thus, in private law, it may be important in relation to the question whether the physician is entitled to compensation for services rendered in an emergency situation.

In seeking to explain the juristic basis on which the emergency treatment rests, various divergent views have been put forward. We have already rejected the idea of a general professional right. Some jurists regard implied or presumed consent as the ground of justification. The criterion here would be whether the nature of the treatment is such that the patient would probably have given his consent to the treatment had he been capable of doing so. Sometimes the treatment is regarded as justifiable simply on the ground of emergency, without attempting to find any further ground.

In current South African law, emergency (“necessity”, “inevitable evil”) is in fact regarded as a general ground of justification. A characteristic of a typical emergency situation, however, is that the interests of an innocent third party are sacrificed to protect the interests of the person threatened. See Snyman CR *Criminal law* 4 ed (2002) 113–120; Burchell J *Principles of criminal law* 3 ed (2005) 257. (But also see Neethling et al 82 fn 339.) This pattern is absent in most cases of medical treatment. The person threatened (the patient) is generally also the person in respect of whom the “protective act” occurs.

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

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

Negotiorum gestio is the ground of justification in our common law which is best suited to a situation related exclusively to the interests of a patient and

not to the interests of society. See De Wet JC & Swanepoel HL *Strafreg* 4 ed (1985) 97. *Negotiorum gestio* in its common-law origin is ordinarily concerned with the protection by one person of the patrimonial interest of another in the absence of this last person. See Rubin L *Unauthorised administration in South Africa* (1958) 2–3. However, there is no reason why this doctrine should not be extended to a situation where the party who is “threatened” is in fact physically present but psychologically “absent” due to unconsciousness. In any event, absence from the place where the *gestor* acts is not a requirement for *negotiorum gestio*. The only requirement is that he should be unaware of the protection of his interests by the *gestor*. See Rubin 22–23. A person who is unconscious can no more protect his own interests than a man who is a thousand kilometres away.

Furthermore there is no reason why *negotiorum gestio* cannot also include the protection of the interests of personality. Our common-law authors have acknowledged *negotiorum gestio* also where a person provided maintenance for the children of another. See Rubin 41–42. The support of children, after all, is not concerned primarily with the protection of a patrimonial interest of the father. In any event, an act aimed directly at protecting a personality interest often indirectly promotes the protection of a patrimonial interest. If a doctor operates timeously on an unconscious patient, he may by his action avert grave complications which might later cause the patient medical expenses amounting to thousands of rand and which might result in occupational disability (and the resultant lack of income). It may, however, be better to speak of “analogous *negotiorum gestio*” with regard to the protection of the interests of personality.

In so far as they are relevant here, the requirements of *negotiorum gestio* may be briefly summarised as follows:

- (1) It goes without saying that a necessity for the intervention must exist.
- (2) The *gestor* must promote the interests of the *dominus* without the latter’s authorisation and knowledge of such promotion.
- (3) The *gestor* must act with the object of serving the interests of the *dominus*. See Rubin 48.

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. See *S v Kramer and Another* 1987 (1) SA 887 (W). In this case a catastrophe occurred when an anaesthetist failed to insert an endotracheal tube correctly and the surgeon in vain applied desperate measures to try and save the patient’s life.

Before concluding our discussion of emergency treatment, the last instance yet to be mentioned is that where treatment occurs without the consent of the patient and where neither the traditional situation of necessity (a violation of the interests of an innocent third party), nor *negotiorum gestio* (promoting the interests of someone who is incapable of giving his consent) is present. This situation presents itself where in operating on or treating a patient it is important to deliberately avoid informing the patient of his condition since such knowledge would probably affect his state of mind so adversely that it would not be in his best interest. This type of situation can be classified under the so-called “therapeutic privilege” to which we have already made

reference above when we discussed the doctrine of informed consent. In such cases, where the physician is in a dilemma, it is submitted that the physician's conduct should be lawful on the ground of therapeutic privilege without being covered by any legally valid consent. (See Coetzee LC "Medical therapeutic privilege, a separate and independent defence *eo nomine*" 2004 TSAR 464–481.)

The parameters of therapeutic privilege have not yet been established in our law, and furthermore they are ethically controversial. In practice doctors occasionally rely on therapeutic privilege in extreme cases. Some doctors, however, flatly refuse to withhold any information from their patients on the ground that this would be dishonest. There is also controversy in the medical profession about therapeutic privilege.

In 1.6 above we touched on the constitutional provision (contained in s 27 of the Constitution), whereby "no one may be refused emergency treatment". This clause was commented upon by the Constitutional Court in the case of *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC). See our discussion of the case above.

On emergency treatment in general, further see Strauss 89 et seq.

ACTIVITIES

1. Draw up a list to describe the basic legal principles whereby medical interventions are justified — which, in other words, would make medical procedures lawful instead of unlawful.
2. Dr A is travelling by car to his consulting rooms when he comes across a road accident. He notices that someone who was clearly badly injured is lying by the side of the road. Is the doctor (a) legally bound to stop and render first-aid to the injured person, or (b) legally entitled to do so? Note that the injury is so serious that the injured person is unable to give consent to anything. Recommend what Dr A's course of action should be.
3. Mrs Y presents to Dr X with a complaint of persistent and severe pain in her neck and shoulders. Dr X diagnoses nerve root oppression (a "pinched nerve") in her spinal column due to a bony growth. He proposes surgery to "free" the nerve. Dr X warns Mrs Y of the possibility of disturbing a nerve root and the possible harmful consequences thereof. However, he does not mention the possibility of damage to the spinal cord itself, even though he knows that he would be operating within three millimetres of it. The risk of such damage is less than one per cent, but if the risk would materialise, the resulting injury could be very severe. The patient consents to the operation which is carried out by Dr X, a specialist surgeon, with due care and skill. Unfortunately the spinal cord is injured and Mrs Y suffers partial but irreversible paralysis. Can Dr X be held liable on the grounds of lack of informed consent on the part of Mrs Y?
4. To what extent may (a) minor patients, and (b) mentally ill patients consent independently to medical treatment and operations?

FEEDBACK

1. (a) The fundamental legal basis for medical interventions in most cases is consent, either by the patient herself or someone who is legally empowered thereto, on her behalf. There are other principles, however, that may also be applicable in other situations.
 - (b) Thus the principle of unauthorised administration in analogous form may come into place where the patient is unable to consent and it is impracticable to seek consent from a legal representative.
 - (c) There is, thirdly, the possibility of a statutory provision authorising medical intervention in the public interest, even against the will of the patient.
2. There is no absolute duty on the part of the doctor to treat the accident victim. The doctor may have pressing duties elsewhere. In the final analysis the answer to this question depends on the *boni mores* (the juristic notions of society). Note also the provisions of the Constitution and the National Health Act in terms of which nobody may be **refused** emergency medical care. But the doctor undeniably has the right to intervene and to come to the rescue of the patient in this emergency situation.
3. The doctor might argue that a one per cent risk is so negligible that the reasonable doctor would not have warned the patient of the existence of such a risk. However, in South Africa today it is doubtful whether the criterion of the reasonable doctor should be applied. We are of the opinion that the “material risk” criterion applied in the *Castell* case should be applied, namely whether the reasonable patient would have regarded it as a significant risk; that is, whether Mrs Y herself — to the knowledge, or presumed knowledge of Dr X, would have done so. A court may well find that Dr X had failed to adequately inform Mrs Y.
4. The answer to this question depends partially on the common law as well as statutory provisions discussed in parts 5.2.2 and 5.2.3 of this study unit.

STUDY UNIT 6

Legally recognised medical procedures

Contents

- 6.1 Introduction
- 6.2 Therapeutic procedures
 - 6.2.1 The objective to cure
 - 6.2.2 The objective: anaesthesia or euthanasia
 - 6.2.2.1 Anaesthesia
 - 6.2.2.2 Active euthanasia
 - 6.2.2.3 Passive euthanasia
 - 6.2.3 The objective: behaviour modification or change of personality
- 6.3 Non-therapeutic procedures involving healthy persons
 - 6.3.1 Prophylactic measures
 - 6.3.2 Curative purpose
 - 6.3.2.1 Anatomical donations by living persons
 - 6.3.2.2 The removal of tissue from dead bodies
 - 6.3.3 No curative purpose
 - 6.3.3.1 Pointless operation
 - 6.3.3.2 Cosmetic operation (plastic surgery)
 - 6.3.3.3 Castration
 - 6.3.3.4 Sterilisation

Activities
Feedback

Learning outcomes

- When you have completed this study unit you should be able to
- distinguish between therapeutic and non-therapeutic procedures
 - explain whether the legal principles derive from common law or statutory law, and apply them to a range of medical procedures such as anaesthesia, euthanasia, behaviour modification, prophylaxis, anatomical donation, cosmetic operations, castration and sterilisation
 - distinguish between three comparable but different forms of potential liability that may flow from the birth of a child, namely wrongful conception, wrongful birth and wrongful life, and advise clients on the basis of evidence provided in a case study

6.1 Introduction

In the preceding sections we discussed the grounds of justification relating to medical treatment. We indicated that consent cannot be raised as a defence justifying each and every type of treatment undertaken by a medical

practitioner. In this study unit we discuss the question of the juridical limits within which medical procedures are lawful.

Two kinds of medical procedure can be distinguished:

- (1) a healing (therapeutic) procedure, that is treatment of an ailing person with a view to curing him
- (2) a non-therapeutic procedure which is performed on a healthy person by the application of medical science

Different considerations play a role in adjudicating these interventions, and it is therefore desirable to treat the two kinds separately. However, as we shall see, it is not possible to draw an absolute distinction between the two types of procedure, because some non-therapeutic procedures may also serve a therapeutic objective to some extent.

6.2 Therapeutic procedures

6.2.1 The objective to cure

The lawfulness of an operation or treatment undertaken with the aim of effecting a cure is beyond any doubt, provided that a ground of justification (such as consent or *negotiorum gestio*) is present.

It need hardly be stressed that an intention to cure must be present. If an act of aggression takes place against the person of another without this aim, and by happy coincidence it has the effect of curing the victim of his disease — such cases have been described — the unlawfulness of the act of aggression is not invariably purged by the consent of the person who has been cured. (In criminal law, this fortuitous result may perhaps constitute a mitigating circumstance, and in the law of delict law it may affect the *quantum* of damages.)

The treatment need not necessarily be performed by a qualified or registered medical practitioner (doctor, nurse, etc). Everyday life is full of instances where professionally unqualified persons perform “operations” or give some form of therapeutic treatment. However, in the case of drastic treatment, it must take place in accordance with the principles of medical science, and in the case of treatment which is not of a drastic nature, at least in accordance with the rules of everyday hygiene. (Schwietering K “Insake: Lampert v. Hefer, NO, 1955 (2) S.A. 507 (A)” 1957 *THRHR* 138, 140 rightly observed that in emergency situations the intervention of less competent persons can be justified.) If the treatment satisfies these requirements, its ultimate success or failure is not a factor. No medical operation or treatment is assured of absolute success. Medical science is also subject to limitations, and even well-tested remedies can fail in a particular case. The possibility of success might be comparatively slight but the treatment may nevertheless be lawful. Even treatment undertaken by experienced medical practitioners who apply recognised methods, is frequently experimental to a certain extent.

Consent to reckless experiments with no consideration for recognised practices, however, is undoubtedly *contra bonos mores* and the treatment is consequently unlawful. Human life and physical integrity are regarded too highly in the West today to become the objects of dangerous experimentation.

A few limitations apply here, however. Brief, temporary injuries of an experimental kind, aimed at effecting a cure (“therapeutic innovation”) must be regarded as lawful. Infliction of serious harm, on the other hand, is forbidden. In order to be lawful, experimentation must to a certain extent be unavoidable. If other recognised procedures or methods of treatment can be effective, there can be no possible justification for applying those which are unknown. If the experiment can be satisfactorily performed on an animal, it would undoubtedly not be lawful to attempt it on a human being. Where, on the other hand, the patient cannot be saved from certain death by any other known means, even a dangerous experiment with little chance of success will be fully justified.

Not only will a directly curative intervention be lawful if it fulfils the requirements described, but also the essential procedures that precede it, such as the administering of an anaesthetic or a purgative.

On human experimentation in general, see our discussion in study unit 7, part 7.3.

6.2.2 The objective: anaesthesia or euthanasia

6.2.2.1 Anaesthesia

The administering of anaesthesia in order to minimise the patient’s pain and discomfort during an operation has become an important form of medical treatment. It may even constitute negligence if ineffective anaesthesia is administered. Thus, in England, a woman was awarded damages in an amount equivalent to R75 000 in consequence of pain suffered by her when a caesarean section was performed on her while she was insufficiently anaesthetised. She had been given muscle relaxants before surgery and was unable to show that she was feeling pain (*The Citizen* 23 March 1989).

The administering of drugs to relieve pain where there is no longer any hope of recovery for the patient and therapeutic treatment is no longer administered, is, of course, also a lawful practice.

6.2.2.2 Active euthanasia

The causing of death by a positive action, on the other hand, is **unlawful in principle**. Consent to homicide is no defence in our law. See *R v Peverett* 1940 AD 213; *S v Robinson and Others* 1968 (1) SA 666 (A).

In *R v Dawidow* (unreported; a concise report by Van Dyk HP appears in 1956 *THRHR* 286) a man was accused of murder after having shot his painfully suffering mother in hospital with a revolver in order to release her from her suffering. It was submitted in defence that the accused was *doli incapax*. The jury found the accused not guilty. As Van Dyk rightly shows, there was no recognition here of euthanasia as a lawful procedure.

Compare with this *S v De Bellocq* 1975 (3) SA 538 (T), a case of euthanasia where there could, however, be no request or desire on the part of the sufferer. A young married woman had brought her first child into the world. Shortly after the birth it became apparent that the child was suffering from an incurable disease, toxoplasmosis, the effect of which is that the sufferer’s

brain becomes irreparably damaged. The child would have led a completely “vegetative” existence and would probably not have lived for any length of time. The mother, a medical student, was au fait with all the facts and implications. In a state of emotional shock and deep depression she killed the child by drowning it in a washbasin. She was accused of murder and found guilty but was not sentenced. The judge merely imposed an order in terms of section 349 of the Criminal Procedure Act then in operation, without requiring recognisances.

Euthanasia, therefore, is unlawful whether it takes place at the request of the sufferer or otherwise. If a medical practitioner were to take positive steps — were, for example, to administer an overdose of drugs — in order to cause immediate death or to hasten death considerably, he would consequently be guilty of murder. See *S v Hartmann* 1975 (3) SA 532 (C). In this case a medical practitioner took the life of his ailing father. The father, an old man of 87, had suffered from cancer of the prostate for some years. The cancer later spread to other parts of his body. The deceased was bedridden and emaciated when, at a certain stage, further complications ensued, including a pulmonary embolus (blood clot in the lung). He was treated with pain-killing drugs and it seemed that he was already moribund. A nurse administered a considerable dose of morphine to the deceased on the instructions of the accused. The accused himself later administered further morphine as well as a dose of pentothal (a drug used in anaesthesia). The deceased died within minutes of the administration of the pentothal. The court held that the accused was guilty of murder. In his judgment Van Winsen JP pointed out that it was unlikely, on the evidence before the court, that the father had expressed a wish to die. Even were that the case, however, it would not have constituted a defence. The judge held that there were strong mitigating factors present and he sentenced the accused to a term of imprisonment of one year, the entire period being suspended with the exception of the detention of the accused until the rising of the court.

According to a South African judgment, to hasten death is in fact to cause it. In *R v Makali* 1950 (1) SA 340 (N) 344 the court declared as follows:

The true enquiry is whether the deceased would have died when he did but for the [accused’s] unlawful act. If this enquiry gives an affirmative answer, [accused] is responsible for the death because he caused it to take place when it did, that is to say because he hastened it.

This is also the general point of departure in English law (see Williams G *The sanctity of life and the criminal law* (1958) 289), but there is authority for the proposition that a medical practitioner may by the administering of drugs lawfully shorten the life of a patient. In the prosecution of Dr John Bodkin Adams (quoted by Williams 289) in 1957, the judge instructed the jury in the following terms:

If the first purpose of medicine, the restoration of health, can no longer be achieved there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measure he takes may incidentally shorten life.

According to the judge this does not amount to causing death; the disease must be regarded as the cause.

Williams (285 *et seq*) is of the opinion that a physician's conduct is not unlawful in the following instances:

- (1) A patient is suffering from an incurable disease accompanied by excruciating pain. The physician administers the minimum dosage of drugs necessary to make the pain endurable knowing that such minimum dosage will probably also cause death.
- (2) A patient is suffering from a painful and incurable disease and a drug is administered. Because of the resistance consequent upon the habitual administering of the drug, steadily increasing doses have to be administered. This means that unless the patient dies beforehand owing to another cause, a point must be reached when the dosage becomes lethal.

We share this view. Kahn E (*The sanctity of human life* (1984) 24 at 25) is correct in pointing out that “[t]he doctor who, in genuinely and reasonably attempting to relieve the pain of his patient, indirectly hastens the death of his patient, is not guilty of murder, because his conduct was not unlawful”. (See also *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D) 656 H–I)). As Leenen (in an unpublished paper) has observed, the doctor's intention in this situation is not to end the patient's life, but to relieve the patient's suffering. He argues as follows:

The administration of the pain-alleviating method can be qualified as an act with double effect. It must not be defined according to its side-effect, the unavoidable shortening of life, but according to its aim, which is to combat the pain of which the patient is suffering. Many medical acts and drugs have side-effects, but nobody will define them from the viewpoint of these side-effects. The same is true for painkilling.

(Cited by Strauss 346.)

Where it appears that the condition of a patient who is suffering painfully is such that no treatment can avert death, but the patient's life may be slightly prolonged by the administering of drugs, the conduct of the physician will in our opinion not be unlawful if he fails to administer the drugs (see Williams 291).

In so far as the positive conduct of the physician is concerned we have thus far dealt only with the administering of drugs by the physician himself. What is the position 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? Where the administering of a drug is lawful, there cannot be any difference in principle between the administering and the providing of the drug. The question which arises, however, is whether it makes any difference in instances where the administering of the drug is unlawful. We shall return to this question in the discussion of murder and culpable homicide.

On euthanasia generally, also see Rall A “Matters of life and death: relieve suffering or prolong life” 1977 *SALJ* 40 and Strauss 336.

6.2.2.3 *Passive euthanasia*

The term “active euthanasia” is used to describe the situation in which a person deliberately takes steps to put an end to the life of a person who is suffering from an incurable disease — as occurred in the cases of *Davidow*, *De Bellocq* and *Hartmann* discussed above.

As opposed to this situation, there is the situation where a person is kept alive artificially by medical means, and the attending doctors decide that there is no purpose in continuing resuscitative or life-sustaining measures. Where such treatment is discontinued, resulting in the patient’s death, the term “passive euthanasia” is sometimes used. (There are those, however, who argue that the use of the word “euthanasia” in this context is altogether unacceptable.) Difficult ethical, legal and religious questions arise in regard to this situation. The debate around these issues is known as the “right to die” debate. A number of cases have been decided by courts of other countries, particularly of the USA. The best-known of the American cases were those of Karen Quinlan (1976) and Nancy Cruzan (1991).

The first decision of a South African court on the “right to die” was handed down in the case of *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D). It is a landmark judgment which clarified several major legal issues relating to the withdrawal of life-sustaining treatment in a case of terminal illness and, particularly, in cases of patients who are in a persistent vegetative state (PVS).

The case concerned the tragic fate of Dr Clarke, a well-known Natal medical practitioner and politician, who in his lifetime had also been MEC responsible for hospital services in that province for a period of five years. He was a member of the SA Voluntary Euthanasia Society and before his last illness had signed the living will.

In July 1988 and while undergoing epidural treatment, Dr Clarke — who was 63 years of age at the time — suffered a sudden drop in blood pressure and went into cardiac arrest. His heartbeat and breathing ceased. Resuscitative measures were instituted but by the time that his heartbeat and breathing were restored, he had suffered serious and irreversible brain damage due to prolonged deprivation of oxygen to the brain (cerebral anoxia). He had become deeply comatose and remained in that condition permanently.

In the judgment of the court Thirion J commented on certain public statements made by Dr Clarke in 1983:

These statements undoubtedly stemmed from a settled, informed and firmly held conviction on [his] part that should he ever be in the condition in which he has been since the cardiac arrest, no effort should be made to sustain his life by artificial means but that he should be allowed to die.

Some three years after the tragedy that befell Dr Clarke, his wife approached the court for an order appointing her as curatrix of her husband’s person, with powers *inter alia* to withhold agreement to any medical treatment for her husband, and to authorise the discontinuance of any treatment, including any naso-gastric or other non-natural feeding regime or like regime for the hydration of the patient.

The Attorney-general of Natal opposed the application on a number of grounds. One of the main grounds of opposition was summed up by the judge thus:

The discontinuance of the artificial feeding would hasten the patient's death and would thus be a cause of it and as the applicant foresees death as a probable result of the discontinuance of the artificial feeding, she would in law be liable for having unlawfully killed the patient.

In advancing this argument, the Attorney-general relied *inter alia* on the two 1975 “mercy-killing” cases of *Hartmann* and *De Bellocq*, respectively, in which it had been held that an intentional killing is murder even though the killer did not harbour any evil motive. On the facts of the *Clarke* case, however, the judge refused to uphold that argument. The issues in the present case, the judge said, “can only be approached after a thorough evaluation of the patient's physical and neurological deficits and the extent of the biological and intellectual life which still remains to him”.

The specialist physicians and neurologists who had examined the patient were in agreement that he was in a **persistent vegetative state** because of the extensive damage to the cortex — that part of the brain which is responsible for intellectual function and cognitive awareness. They also agreed that the damage was irreversible and that no improvement was possible. **It is to be noted, however, that Dr Clarke was *not* brain-dead.**

The term “persistent vegetative” describes a neurological condition where the subject retains the capacity to maintain the vegetative part of neurological function but has no cognitive function. In such a state the body is functioning entirely in terms of its internal controls. It maintains digestive activity, the reflex activity of muscles and nerves for low-level and primitive conditional responses to stimuli, blood circulation, respiration and certain other biological functions, but there is no behavioural evidence of either self-awareness or awareness of the surroundings in a learned manner. The patient did not experience pain or discomfort because he had lost the capacity to experience these sensations. “But,” said the judge,

[t]here is ... no doubt that legally the patient is still alive; nor is death imminent. His life expectancy is uncertain. The discontinuance of nasogastric feeding and any other form of nourishment is bound to lead to the termination of such life as the patient still has.

In deciding the case, the judge was not prepared to give absolute recognition to an advance directive (eg in the form of the living will). (It is relevant to observe here that we do not have legislation in South Africa, as yet, regulating advance directives or durable powers of attorney — as have the majority of states in the USA.)

In *Clarke* the patient's *curator ad litem* argued as follows:

An adult of full legal competence has, while of sound mind, an absolute right to the security and integrity of his body. In the exercise of that right he is entitled to refuse to undergo medical treatment, irrespective of whether such refusal would lead to his death Where, as in the present case, such a person while he is of sound mind, has directed that

should he lapse into a persistent vegetative state with no prospect of recovery, he should be allowed to die and that he should not be kept alive by artificial means, then if he does lapse into such a state, there is no reason why a curator appointed to his person should not have the power to give effect to his direction.

Thirion J refused to uphold that contention, though, ruling as follows:

The fallacy of counsel's argument lies in the fact that in our law the *curator personae* is not a mere agent to give effect to the directions given by the patient while he is competent to do so. 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 well-being of the patient being the paramount consideration. In our law, the court would not simply weigh the patient's interest in freedom from non-consensual invasion of his bodily integrity against the interest of the state in preserving life or the belief in the sanctity of human life; nor would it necessarily hold that the individual's right to self-determination and privacy always outweighs society's interest in the preservation of life. Furthermore, in our law a person who assists another to commit suicide may, depending on the circumstances of the particular case, be guilty of murder or culpable homicide

It is clear that the judge was not prepared to give full recognition to generally held modern medical views on patient autonomy. His ruling on this point was nevertheless not decisive as far as his ultimate finding in *Clarke's* case was concerned.

The essence of the ruling in *Clarke* was that discontinuance of medical treatment in the circumstances of the case would not be unlawful. In sum, the reasoning of the court was as follows: **The decision whether the discontinuance of the artificial nutritioning of the patient and his resultant death would be wrongful, depends on whether, judged by the *boni mores* of our society, it would be reasonable to discontinue such nutritioning. This decision relates to the quality of life that the patient still enjoys.**

Advances in medical science and technology, the judge said, have made it possible for patients who suffered a cardiac arrest and cessation of breathing and who according to the ordinary manner of thinking would therefore have been regarded as dead, to be resuscitated. Inherent in resuscitation, however, is the real danger that, by the time the patient has been resuscitated, his brain may be all but destroyed, while the autonomic nervous system and brain stem may nevertheless be able to keep the body biologically alive but securing only a life at the level of a plant or less. "In such a situation the doctor or the patient's family has to decide whether it would be justified or reasonable to institute or maintain life-sustaining procedures which could prolong the life of the patient."

According to the judge, **it can never be said, though, that the "external decision maker" has a *right* to impose death.** The judge referred to American and English cases which bear out the conclusion that in those countries societal attitudes permit the decision whether to maintain life-sustaining measures, based on an evaluation of the quality of life which the patient

would be ensured through the taking of such measures. In the present case the judge said that the applicant — the patient’s wife — intended to withhold nutrition from the patient. The court acknowledged that **feeding ordinarily has a special symbolic significance, but in the present case the artificial feeding did not have any such symbolic significance at all because the patient was quite unaware of it and would be equally unaware of it if it was withheld.**

The hastening of a person’s death is ordinarily not justified and is therefore wrongful even when the person is terminally ill and suffering unbearable pain This is, however, no absolute rule. It has come to be accepted that the doctor may give a terminally ill patient drugs with the object of relieving his pain, even if, to the doctor’s knowledge, the drugs will certainly shorten the patient’s life ...

The judge also referred to the instance of a patient with brain damage who is attached to a ventilator: he is unconscious, but the machine keeps his heart and lungs going mechanically. The doctor decides that there is no chance of recovery so he “pulls the plug”. “On the principles of our law,” the judge said, “the doctor would in each of the above examples be exempt from liability if, judged by the legal convictions of society, his conduct was reasonable.”

Why then would it not be reasonable for someone to simply kill the patient by suffocation? The distinction, Thirion J said, “is to be found in society’s sense of propriety — its belief that things should happen according to their natural disposition or order”. The doctor who, while following the precepts and ethics of his profession, prescribes a drug in a quantity merely sufficient to relieve the pain of his patient, is one who “acts within the legitimate context and sphere of his professional relationship with his patient”. Consequently, society adjudges his conduct justified in accordance with its criterion of reasonableness, and therefore not wrongful.

The judge was further of the opinion “that in determining legal liability for terminating a patient’s life there is [no] justification for drawing a distinction between an omission to institute artificial life-sustaining procedures and the discontinuance of such procedures once they have been instituted”. Nor did he think that there is any virtue in classifying the discontinuance of such procedures as an omission.

The court was, therefore, of the view that, judged by society’s legal convictions, the feeding of the patient “does not serve the purpose of supporting human life as it is commonly known”, and accordingly his wife, if appointed as curatrix, would act reasonably and would be justified in discontinuing the artificial feeding, and would not be acting wrongfully if she were to do so.

According to the court, this conclusion made it unnecessary to deal with the argument advanced by her counsel that such discontinuance would not in law be the cause of the patient’s death if he were to die as a result thereof.

The court nevertheless referred in this regard to the Appeal Court decision in *S v Williams* 1986 (4) SA 1188 (A). The victim in that case had been shot and wounded. She had suffered severe brain damage which had necessitated her

being coupled to a ventilator to maintain her breathing. When it was ascertained that her brain was dead, the ventilator was uncoupled and her heartbeat and breathing ceased in consequence thereof. On appeal the argument was raised that the uncoupling of the ventilator and not the gunshot wound had been the legal cause of the victim's death. The Appeal Court rejected that argument, however, ruling 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.

Thirion J observed that the uncoupling of the ventilator had accelerated the patient's death in the *Williams* case "and therefore in a sense caused it". It is clear, however, that a factual causal connection is not enough to incur legal liability. "Matters of policy" also are relevant to the enquiry, and the court should guard against allowing liability to exceed the bounds of reasonableness, fairness and justice. The judge was of the opinion that the steps envisaged by Mrs Clarke would not in law be the cause of the patient's death.

Lastly, it had to be decided whether the steps which Mrs Clarke proposed to take would be in the best interests of the patient. It had to be stressed that the court approaches those interests with a strong predilection in favour of the preservation of life, which however does not extend as far as requiring that life should be maintained at all costs, irrespective of its quality.

It is indeed difficult to appreciate a situation, save where the patient is suffering unbearable pain or is in a vegetative state, where it would be in his best interests not to exist at all. The patient in the present case has however passed beyond the point where he could be said to have an interest in the disposal of his body so I think the patient's wishes as expressed when he was in good health should be given effect to.

In the event Mrs Clarke was appointed as curatrix to the person of her husband with the power, *inter alia*, to withhold agreement to medical treatment of the patient and to authorise the discontinuance of any treatment.

It is to be noted that there is nothing in the judgment to suggest that it would be necessary in all cases of this kind for a *curator personae* to be appointed first. This was what the applicant in *Clarke's* case had actually applied for. **The crux of the case is that discontinuance of treatment *in casu* would not have been wrongful.**

It is clear that even in the absence of formal appointment of a curatrix to articulate a decision to discontinue treatment, such a decision — whether taken by her and executed by the attending doctors or whether taken by the latter with her concurrence — would in the circumstances of the case not have been regarded as wrongful. In fact, **it would seem that a decision taken by the doctors on their own would have been regarded as reasonable and, therefore, lawful.** It is clear that in the event of a dispute, the doctors in a case of this kind may be called upon to justify their action, and thus circumspection and careful documentation of the investigations and circumstances are absolutely necessary.

Thirion J handed down his judgment on 30 July 1992. The Natal Attorney-general announced soon after the judgment that he had decided not to appeal

against it, saying it could take the Appellate Division considerable time before giving a decision. He wished to avoid any further torment to Dr Clarke's family. It was reported by the media shortly afterwards that Dr Clarke was taken home from the hospital where he had been treated, and died peacefully on 14 August 1992.

It is also to be noted that in the late 1990s the SA Law Commission published a report in which it recommended, *inter alia*, statutory recognition of living wills and a procedure to regulate termination of life-sustaining procedures in the case of terminally or gravely ill patients, including what can broadly be termed doctor-assisted suicide. So far these controversial recommendations have not yet resulted in legislation. The final report was tabled in Parliament at the beginning of 2000.

With regard to euthanasia, see also our discussion of doctor-assisted suicide below in study unit 8, par 8.5.

6.2.3 The objective: behaviour modification or change of personality

A controversial type of operation is brain surgery performed on an individual who is perfectly healthy in the physical sense of the word, but who is suffering from a mental illness or personality disorder such as psychopathy, which results in antisocial or dangerous behaviour.

An example of such an operation is a leucotomy, which is an operation on the brain with the object of isolating the frontal lobes (the intellectual or emotional areas) from incoming impulses. This operation has been found to result in an improvement in the case of certain mental disorders, especially those associated with unbearable emotional distress. The operation results in personality changes, for example decrease in inhibitions, which may be a severe disadvantage and are incurable, and is therefore performed only in extreme cases after all other measures have failed (Levitt *Short Encyclopaedia of Medicine for Lawyers* *sv* "leucotomy").

Serious doubt exists about the lawfulness of such drastic brain surgery. (See the remarks of Jansen JA in *S v V* 1972 (3) SA 611 (A) at 622. In that case a convicted rapist sentenced to death in vain sought leave to lead further evidence on appeal on the possibility of brain surgery which may have the effect of destroying or dampening the sexual drive.)

Regulation 7 under the now repealed Mental Health Act 18 of 1973 (see GN R565 of 27 March 1975) regulated the performance of leucotomies. This regulation has been repealed by regulation 48(1) made under the Mental Health Care Act 17 of 2002 (see GN R1467, GG 27117 of 15 December 2004).

With the introduction and increasing use of a growing number of anti-psychotic drugs during the latter half of the twentieth century, the performance of leucotomies declined drastically.

6.3 Non-therapeutic procedures involving healthy persons

Three kinds of procedures are conceivable here:

(1) prophylactic measures applied to a healthy person

- (2) procedures involving a healthy person with the object of eventually curing an ailing person
- (3) operations performed without any curative purpose whatsoever

6.3.1 Prophylactic measures

A medical procedure performed upon the body of a healthy person to counter disease (prophylaxis) is not only a recognised practice in the modern world, but is most praiseworthy, and its lawfulness is unimpeachable. Vaccination may serve as an example.

6.3.2 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 the health of another person who is ailing. Examples of such procedures are the withdrawal of blood for the purpose of transfusion, which is a common practice nowadays, and removal of tissue such as skin, or of an organ, such as a kidney, for transplantation in or upon an injured or diseased person.

Blood transfusion is governed by comprehensive regulations (GN R1935, GG 12695 of 17 August 1990) under the Human Tissue Act 65 of 1983.

The donation of human tissue is governed by the Human Tissue Act 65 of 1983 which replaced the Anatomical Donations and Post Mortem Examinations Act 24 of 1970. This latter Act was a direct result of the spectacular heart transplant operations, the first of which had been undertaken by Dr Christiaan Barnard in Cape Town at the end of 1967. These operations led to a searching re-examination of medical, ethical, legal and religious attitudes concerning the removal and grafting of human tissue.

The Human Tissue Act is largely a consolidating measure, also incorporating earlier legislation relating to the acquisition of corpses for use in medical schools. However, the Human Tissue Act also brought several innovations in respect of the transplantation of tissues and organs. Important amendments were effected in 1984 and 1989. Please note that the National Health Act 61 of 2003 envisages the repeal of the Human Tissue Act 65 of 1983. Chapter 8 of the National Health Act 61 of 2003 contains provisions relating to the control of the use of blood, blood products, tissue and gametes in humans, and will replace the Human Tissue Act once it comes into operation. Our discussion of the Human Tissue Act 65 of 1983 will therefore be materially affected by chapter 8 of the National Health Act 61 of 2003.

There is a constant shortage of organs for transplantation in South Africa, and it is widely felt that the Human Tissue Act is too restrictive.

6.3.2.1 Anatomical donations by living persons

The Human Tissue Act 65 of 1983 governs the removal of tissue, blood or gametes from the bodies of living persons for therapeutic and other uses. The Act defines “tissue” as “any human tissue, including any flesh, bone, organ, gland or body fluid, but excluding any blood or gamete”, and “any device or object implanted, before the death of any person”. In the Act, “gamete” is

defined as “either of the two generative cells essential for human reproduction”, that is the male sperm and the female ovum (s 1).

The Act provides for the use of tissue, blood and gametes removed or withdrawn from the body of a living person for medical and dental purposes. This use includes the transplanting of tissue, the production of a therapeutic, diagnostic or prophylactic substance, the transfusing of blood, the production of a blood product and, in the case of a gamete, artificial insemination (s 19). (It is to be noted that the Act makes no reference to purely scientific research and experimentation, and it is doubtful whether such activities could be described as “medical”.)

Tissue, etcetera, obtained from mentally ill persons may not be used for any of the said purposes; nor may tissue which is not replaceable by natural processes, or the gamete of a minor be used. (A minor may, however, donate blood, skin and the like.) Similarly, a gamete obtained from a habitual criminal may not be used. Tissue from the placenta, foetus and umbilical cord may not be used, except with ministerial consent (s 19).

Tissue destined for transplantation may be removed only in a hospital or other authorised institution (ie authorised by the Minister of Health). The medical superintendent of the hospital or institution must provide a written authorisation, and may not carry out the transplant himself (s 20). Note that these provisions do not apply to blood or gametes.

The removal of tissue, blood and gametes for any of the above-mentioned purposes may be effected only with the consent of the donor — in the case of a minor, the consent of his parents or guardians. This consent must be given in writing, except in the case of blood or tissue replaceable by natural processes. Moreover, in the case of donors of fourteen years or older who are mentally competent, no parental consent (or consent of a guardian) is required before replaceable tissue and blood may be removed. The minor may give his or her consent either in writing or orally. The Act also provides that tissue removed (with the necessary consent) for the sake of the health of the person concerned (eg bone from a leg amputated after a road accident) may be used for any of the above-mentioned purposes (s 18).

The use of a gonad for transplantation — if the result thereof could be procreation — is illegal, unless the Minister’s written consent thereto has been obtained in advance (s 21). The Act defines “gonad” as “the human organ which produces gametes”, that is a testicle in the case of a male and an ovary in the case of a female (s 1). (Note that artificial insemination is governed by regulations promulgated under the Act. Artificial insemination is defined in the Act in terms so wide as to include *in vitro* fertilisation. This subject is discussed by us in detail below.)

Only medical practitioners, dentists or persons acting under their supervision may remove and transplant tissue, withdraw blood, and administer blood or a blood product for any of the above-mentioned purposes (s 23).

It must be noted that the Act does not provide any guidance on how drastic the operation to remove the tissue may be. It is to be doubted whether a court of law will be prepared to interpret the provisions of the Act as conferring an absolute discretion concerning the removal of tissue upon either the

authorising doctor, the surgeon undertaking the removal or the donor. If such a case comes before our courts, section 20 will probably be interpreted against the background of the common-law principle of *volenti non fit iniuria*.

This will mean that an operation for the removal of tissue will be ruled as unlawful if it is of such a nature that it is considered to be contrary to public policy. A court will have to decide this by carefully weighing the donor's interests against those of the recipient. An obvious condition is that the operation should not substantially imperil the life and health of the donor. Moreover, the removal must be performed in accordance with scientifically-approved methods, as in the case of therapeutic operations. The advantage for the patient should be commensurate with the disadvantage suffered by the donor (Noll P *Uebergesetzliche Rechtfertigungsgründe, im besondern die Einwilligung des Verletzten* (1955) 91).

6.3.2.2 *The removal of tissue from dead bodies*

(Our present topic concerns procedures performed on healthy persons. For the sake of convenience we also treat here removal of tissue from dead bodies, which is also governed by the Human Tissue Act 65 of 1983.)

As we have intimated above, the acquisition of cadaver tissue is (from the juridical point of view) more problematical than tissue donation by live donors. The reason for this is that in civilised societies there is a deep-seated respect for the dead and compassion with the bereaved. (In our common law the violation of a dead body was a punishable offence — see Klopper CF “Diefstal van ’n lyk?” 1970 *THRHR* 38 — and could constitute an *iniuria* to the next of kin — see Joubert 87. Undoubtedly these principles will still apply today.) Religious, humanitarian, aesthetic and hygienic considerations play a role here. Whilst the living donor is in a position to exercise control over the disposal of parts of his body, more extensive legal control is necessary in order to avoid the possible abuse of dead bodies. (It would of course be wrong to think that respect for the dead is a feature of an advanced culture only. In less-advanced cultures the belief in magic may place a very powerful taboo upon unauthorised dealing with dead bodies.)

The donation of human bodies or of tissue from dead bodies is governed by chapter 1 of the Act. The provisions of this chapter are very extensive. It must be noted that the donation of eye tissue is particularly “favoured” by the Act, as was also the case under the 1970 legislation. It was testified before the 1969 Parliamentary Select Committee that, in practice, the strict provisions of the 1952 Act had rendered the acquisition of eye tissue, which today is widely used, extremely difficult (see the report by the Select Committee par 297ff).

(a) *General conditions for legality*

(i) The “donor” must be deceased

Self-evident as this requirement appears to be, no other aspect of anatomical donation has been more intensively debated. Before the days of organ transplants, there was little controversy on the certification of death for the purpose of tissue removal or for other purposes. An organ, it must be noted, differs from other tissue in that it is “a somewhat independent part of the

body that performs a special function” (see Dorland’s *Medical dictionary* sv “organ”) such as the heart, lungs, liver, kidneys, testicles, etcetera. Whereas tissue such as the cornea or skin need not be removed or transplanted to the recipient immediately, but may be stored for an indefinite period, removal of an organ must take place almost immediately after death and it must be transplanted without any delay.

In earlier days the test for death had primarily been the absence of heart activity. 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 the electro-cardiograph (ECG), the absence of spontaneous respiratory movements and the absence of reflexes. See Barnard CN “A human cardiac transplant: an interim report of a successful operation performed at Groote Schuur Hospital, Cape town” 1967 *SAMJ* 1271.

However, the older test does no longer enjoy much support in the medical world. Increased medical knowledge, modern methods of resuscitation and the demands of successful organ transplantation have led to an entirely new approach. Today medical science does not accept that there is any one moment at which a human being dies. It rather sees death as a process which may sometimes be extended over a period of time.

It is generally accepted that, for the continuance of life in the human organism, the combined activity of the brain, heart and lungs is essential. Grave harm to or interference with the function of one of these organs has an almost immediate effect on the others. The most vulnerable of these organs is the brain. When the flow of blood to the brain is interrupted, unconsciousness follows within ten seconds and regular respiratory movements cease within a minute. According to doctors irreparable damage to the brain occurs after five minutes.

Before the advent of antibiotics which prevent infection of the respiratory organs, and of technical devices controlling blood circulation, cases like these were hopeless. Today, however, there is a variety of drugs and machines (eg the heart-lung machine) which have greatly diminished the absolute interdependence of the three organic systems. The mere fact that a heart stops beating does not mean, nowadays, that its “owner” is dead. In certain circumstances the activity of the heart can be restored by means of massage or electric shock.

As we know resuscitation of the heart does not necessarily mean that the patient has been placed on the road to recovery. Although the circulation of blood has been restored, damage to the brain might already be such that the patient has reached — or will soon reach — the stage that may be described as “brain death” or “cerebral death”. When this stage is reached, there is one of two possibilities: either treatment ceases and “heart death” follows within minutes, or treatment is continued and the heart may still function for some time and then cease beating. The occurrence of brain death may be determined by means of the electro-encephalograph (EEG), an instrument used to measure electrical impulses caused by brain activity. The experience of doctors is that, as soon as a reading on this instrument, taken at body temperature, shows “nil” (ie “still” or “iso-electric”), it can mean only one thing in a given clinical context, and that is irreparable brain damage which,

in the absence of further measures, will swiftly be followed by the cessation of other bodily functions.

At this stage the question is whether death must be described as the cessation of both heart and brain activity, or whether brain death is sufficient. If one accepts the latter, it simply means that the physicians may disconnect their apparatus. It also means that an organ intended for use in a transplant may be removed from a body in which the heart is still beating. Certain physicians emphasise that the removal of an organ before the circulation of blood has ceased involves a considerable advantage. This advantage is that the duration of ischaemia (degeneration of the organ by reason of insufficient “feeding” by the blood), where minutes are important, is curtailed.

With little hesitation, therefore, prominent medical men suggested that brain death should legally be accepted as death. In a vegetative existence the only measurable spontaneous reactions are a heart-beat and a measure of blood circulation, which are totally dependent on the artificial lung and increasing doses of drugs. It has been suggested that in these cases we are dealing with nothing more than a living corpse.

While some might still recoil from the suggestion of removing organs from a body of which the heart is still beating, the consensus of medical opinion today is that cerebral death is an acceptable criterion. However, a difficulty is that so far absolute unanimity on the symptoms or indications for irreversible cerebral damage has not been achieved. For this reason our legislature refrained from including a definition of “death” or of “corpse” in the Human Tissue Act. Whether or not death has ensued is therefore a question of fact, and a decision in this regard will, in the event of a dispute, be influenced to a large extent by expert medical evidence.

The Act (s 7(2)) simply provides that, for the purpose of removing tissue, the death of the person concerned must be established by two doctors, one of whom must have been practising for at least five years. These two doctors may not be members of the transplantation team. Eye tissue is specifically excluded from the afore-going provisions. In respect of eye tissue an ordinary death certificate will suffice. It would appear that the certification embodied in section 7(2) does not apply to the removal of tissue in the course of a medico-legal post mortem examination (which is discussed below).

In *S v Williams* 1986 (4) SA 1188 (A), a murder case, — to which we have already referred above in connection with “mercy killing” — the accused raised the defence that the revolver-shot fired by him had not been the cause of the deceased’s death, but that disconnection of the respirator, which — it was contended — constituted an *novus actus interveniens*, had. The trial court found that, according to traditional medical standards, the moment of death is when brainstem death sets in. The accused was accordingly convicted of murder and sentenced to death. The Appellate division confirmed that verdict and sentence. Rabie CJ, however, did not consider that it was necessary to decide whether the medical standpoint of brainstem death was also to be accepted in law. He observed that the issue is one of great interest, not only to criminal law, but also where it concerns other areas of the law, for example the law of succession — where the precise moment of a person’s death can be of cardinal importance. “Medical science”, the Chief Justice

remarked, “understandably perhaps, approaches the problem from a purely mechanical or physical point of view, but in my view moral or even religious considerations, as well as societal attitudes, may become relevant” (our translation). The moment of death — if there is such a thing — therefore, remains an open question in South African law. See generally Van Rooyen RJ *Die moment van dood: ’n medies juridiese ondersoek* LLM dissertation University of Pretoria (1992).

(ii) Who may receive donations?

A donation of the whole body, or of specific parts thereof, may be made to a hospital, a university or technikon, and any other institution authorised thereto by the Minister. A specific doctor or dentist may also be indicated as a donee, or, naturally, in the case of tissue, any person requiring therapy for which the tissue can be used. If no donee is nominated or an institution or person other than those mentioned is nominated, the donation is of no force or effect (ss 3(1) and (2)).

However, it is not necessary for the donor to mention a specific institution by name. Thus, if he simply donates his body to “a hospital”, the nearest hospital is deemed to be the donee (s 3(3)). If the donation has been made to a specific institution which is not within easy reach at the time of the donor’s death, the nearest institution in the appropriate category is regarded as the donee. If a doctor, dentist or patient has been nominated, however, and such person is not within easy reach, the donation likewise falls away (s 3(4)).

If the donor has made conflicting donations, effect is given to the donation made last. However, if the donor had first donated his whole body to one donee and thereafter donated specific tissue to another, the first donation becomes effective (s 3(5)).

(iii) Purposes of donation

A dead human body or specific tissue may be donated to an institution, doctor or dentist for the purposes of medical or dental training, research, the advancement of medicine, dentistry or therapy (this includes the use of tissue in living persons), or for the production of a therapeutic, diagnostic or prophylactic substance. The tissue donated may be used only for these purposes. If the donee is a private individual, it may be donated for therapy. The purpose of a donation need not be expressly stated, but a donation is of no force or effect when made for any other purpose than those stated (s 4). Thus, if A donates his skull to his friend to be kept as a grisly *memento mori*, the donation will be void!

(iv) Consent

Consent to the removal of tissue from a dead body is a prerequisite, except in those cases (discussed below) where removal of tissue may take place in the course of medico-legal autopsies. Consent may be given in one of the following ways:

- (1) By the deceased prior to his death. Such consent may be given in a will or in any document attested by two competent witnesses, who must be

fourteen years of age or older. It may also be given by means of a statement made orally in the presence of at least two such witnesses (s 2). Any donation may be revoked by the donor prior to his death (s 5). However, a relative of the donor obviously cannot revoke or veto a donation made by the deceased.

- (2) By the spouse, any major child, any parent, guardian or any major brother or sister of the deceased, after his death. Such consent can be given only if the deceased has not (prior to his death) forbidden it (s 2(2)). The Act does not provide for revocation of such a donation, and it is submitted that such a donation is incapable of being revoked. Nor, it is submitted, can one relative veto a donation made by another.
- (3) If none of the persons mentioned in the preceding paragraph (ie the spouse, etc) can be traced, the Director-General of National Health (or someone authorised by him) may, instead of such persons, donate specific tissue for the purposes of the Act (s 2(2)). There are two conditions for the validity of such a donation: the deceased must not — prior to his death — have given a contrary instruction; and the Director-General (or person authorised by him) must be satisfied that all reasonable steps have been taken to trace the person referred to in the preceding paragraph (s 2). The question arises whether the official concerned may make such a donation if the identity of the deceased is unknown. In our opinion this question must be answered in the negative. It is difficult to see how the official can be satisfied that all reasonable steps have been taken to trace the relatives if the deceased is unidentified. Further it is to be noted that the Act clearly does not visualise revocation of a donation by the official.

(v) Official authorisation

An act of official authorisation is necessary for the lawful removal of tissue from a dead body. This must be obtained upon request by a medical practitioner or dentist from any one of the following officials:

- (1) the magistrate in whose district the deceased died or where the body of the deceased is present (or another magistrate authorised by him)
- (2) the medical practitioner in charge of a hospital or authorised institution in which the deceased died, or of a mortuary where his body is kept
- (3) any other medical practitioner employed at such hospital, institution or mortuary who has been so authorised by the medical practitioner in charge (s 14(1))

The authorising official must be satisfied that the body or tissue was in fact donated, and that the body is no longer required for an official *post mortem* examination. He must also be satisfied that the removal of tissue is necessary for any of the purposes mentioned above (s 14(2)). The authorisation must be in writing, on the prescribed form. No official authorisation is necessary in the case of the removal of eye tissue (s 7(3)).

(vi) Removal of tissue under medical supervision only

The removal of tissue from a dead body for the purposes of the Act (ie for medical training, research, the advancement of science, therapy, etc) may be

done only by, or under the supervision of, a medical practitioner or dentist. Obviously the tissue must be removed before the body is buried (s 14(2)(a)).

(vii) Gonads excluded

The transplanting of a gonad removed from a dead body which may result in procreation is prohibited in absolute terms (s 16).

(viii) Body not required for *post mortem* examination

Official authorisation may not be given unless the magistrate or medical practitioner is satisfied that the body is no longer required for the purposes of an examination in terms of specified statutes (s 14(2)). These are:

- (1) section 3 of the Inquests Act 58 of 1959 (*post mortem* examination where the deceased apparently died from other than natural causes)
- (2) section 46 of the Health Act 63 of 1977 (*post mortem* examination to establish the possible presence of an infectious disease)
- (3) section 15 (read with sections 16, 17 and 18) of the Births and Deaths Registration Act 15 of 1992 (*post mortem* examination where the deceased is apparently a still-born child but there is doubt whether he is in fact still-born, or where the deceased was not treated by a medical practitioner during his last illness, or where the deceased was so treated, and a medical practitioner was unable to issue a death certificate)
- (4) section 34 of the Occupational Diseases in Mines and Works Act 78 of 1973 (*post mortem* examination of former mine and industrial workers)

Note that, in regard to examinations in terms of the Inquests Act, an exception is made: where the district surgeon or pathologist of the area concerned certifies that, in his opinion, the removal of any specified tissue will in no way affect the outcome of the examination, he may consent to such removal (s 14(3)). The rationale of this exception is that the bodies of healthy young persons who have died as a result of a criminal attack or from accidental causes are an excellent potential source of tissue for transplantation. Moreover, it will frequently happen that where the victim of an assault or accident is brought to a hospital in a state of near death, it is already unmistakably clear what the cause of death will be.

If an organ or tissue were to be removed immediately after the death of such a victim, this would not affect the outcome of the *post mortem* examination, which may take place only days later. Take the example where a patient is brought to a casualty ward with a fatal stab-wound to the aorta. There would be no objection to the removal of his corneae after his death but before the *post mortem* examination.

Special provision is therefore made in the Act (s 14(3)) for the granting of official authorisation for the removal of any specific tissue in medico-legal *post mortem* cases, provided that the doctor who is to conduct the examination (or cause the examination to be conducted) certifies that:

- (1) he is satisfied that the removal of the tissue will in no way affect the outcome of the examination
- (2) he has no objection to the removal of such tissue (s 14(3))

It should be noted that these provisions do not nullify the consent requirements. Accordingly, the body or tissue must have been duly donated for transplantation purposes, either by the deceased, a relative, or, in the circumstances described above, by the Director-General or person delegated by him. However, the Act contains special provisions relating to the removal of tissue or organs during medico-legal *post mortem* examinations without prior consent or official authorisation, which will now be discussed.

(b) Removal of tissue during post mortem examination

Because of the huge shortage of tissue and particularly organs for purposes of transplantation, and the strict general requirements regarding consent, special provision has been made for the removal of tissue (as prescribed by regulation) from a dead body on which a district surgeon or other doctor performs a *post mortem* examination under the Inquests Act 58 of 1959 for donation to an authorised institution.

The provisions relating to consent and official authorisation do not apply. However, no such removal may be carried out if the medical practitioner involved

- (1) is not satisfied that the removal of tissue will in no way affect the outcome of the *post mortem* examination
- (2) at the time of the examination, has reason to believe that the body or tissue has been donated, or that the removal would be, contrary to any direction given by the deceased before his death

These provisions are to be found in section 9 of the Human Tissue Act 65 of 1983. The ambit of the section was broadened in 1989 in order to include diagnostic (“hospital”) *post mortem* examinations.

It is clear that a body donated by a deceased or by any other competent person does not fall within the ambit of this section. It is also clear that any person who objects to routine removal of tissue from his body in the event of an unnatural death may “veto” such removal during his lifetime. However, the section does not create any legal machinery for the recording or registration of such “veto”.

The categories of tissue or organs which may be removed under these provisions have been extended over time. In addition to pituitaries the following types of tissue or organs, *inter alia*, may now be removed by the institutions authorised by the Minister: kidneys, bone, tissue, tendon, cartilage, skin, heart valve, eyes, bone, *dura mater*, liver, aorta, heart, and auricle.

Regulations concerning the requirements with which institutions must comply in respect of bodies and tissue were published by the Minister.

(c) Removal of tissue from bodies of deceased destitutes

A body surrendered to an institution in terms of a formal order issued by the inspector of anatomy in terms of section 12 of the Human Tissue Act 65 of 1983 may be used by such institution, in accordance with the regulations, for any of the statutory purposes such as medical training, research, transplanta-

tion, etcetera. It would appear that the provisions of the Act relating to consent and official authorisation do not apply to such use.

(d) Provisions designed to facilitate tissue acquisition

The Act contains a number of provisions which are designed to facilitate the donation and acquisition of human tissue. Thus the authorising official is empowered to act upon a will if, on the face of it, it appears to be legally valid, irrespective of the fact that the will has not yet been lodged or accepted by the Master of the Supreme Court (s 14(4)). As mentioned above, it is not a requirement for the lawfulness of an anatomical donation that the person making the donation must expressly specify the purpose of the donation. The Act further contains directions regarding conflicting donations. Provision is also made for the nearest hospital to become the donee if the hospital mentioned by the donor is not within easy reach.

(e) Time limit for removal of tissue

Except where the entire body is donated, the donee of tissue has 24 hours following the death of the donor within which he may remove the tissue so donated. After 24 hours have elapsed, whether or not the donee has removed the tissue, the body may be claimed by the relatives of the deceased, or by the person or persons otherwise entitled thereto, with a view to burial or cremation of the remains (s 7(1)).

Proper registers must be kept in respect of anatomical donations (see the regulations contained in GN R2876 of 29 December 1989 GG 12234).

(f) General considerations relating to both deceased and living donors

(i) Rights concerning donated tissue

The person to whom a body or tissue is donated or who acquires tissue (including blood or a gamete) in terms of the Act, is vested with exclusive rights over such body or tissue upon delivery of such body or tissue to him by means of use or otherwise, subject to the prohibition of the sale of tissue (s 36). This provision is especially designed to eliminate the possibility of the relative of a deceased donor and the relatives of a deceased recipient becoming involved in a distasteful conflict over the remains of the donor.

(ii) Sale of tissue prohibited

No person or body except an authorised institution (or, in the case of tissue or gametes being imported, the importer) may receive payment in respect of the import, acquisition or supply of tissues or gametes for any of the purposes sanctioned by the Act. The same prohibition applies to blood or blood products, in respect of which only prescribed institutions are exempted. The rationale for these prohibitions is that most people find commerce in “human flesh and blood” abhorrent. Authorised or prescribed institutions are specifically excluded from the prohibition to enable institutions such as tissue banks (which must incur costs when acquiring and preserving tissue) to be remunerated.

The prohibition on the sale of tissue does not, of course, prevent a medical practitioner from receiving remuneration for any professional service rendered by him to any person.

Note that the unlawful sale of human tissue is a criminal offence. If payment has been made for tissue, gametes or blood in contravention of the Act, the person who made such payment is entitled to a refund (s 28).

(iii) Genetic manipulation

Genetic manipulation of gametes or zygotes outside the human body is absolutely prohibited by the Act (s 39A). (A zygote is the cell resulting from the fusion of two gametes, ie the fertilised ovum.) (In our opinion section 39A prohibits human cloning. See our discussion on cloning below.)

(iv) Secrecy

At the time of the first heart transplants a controversial issue with regard to tissue donation and transplantation was whether the donor and/or recipient should be protected against publicity. It was argued that if the identity of a recipient were known, there would be the possibility of “blackmail” by the donor or his next-of-kin. It was also contended that the fear of publicity could deter potential donors. On the other hand it was felt that the personal freedom of an individual was of too great importance to be fettered by a prohibition against the disclosure of the fact that he was a donor or recipient of human tissue. The legislature ultimately followed a middle course by making lawful disclosure of the identity of the parties dependent upon their consent.

The Act contains a prohibition against the publication to any other person of any fact whereby the identity of the donor of the body of a deceased person or of any tissue thereof, or the donor of tissue removed from the body of a living person, may be established, without consent thereto in writing by the deceased prior to his death or by the living donor, or after the death of the person whose body tissue has been donated by one of the specified relatives who may consent, or by the district surgeon who donated the tissue. The Act contains a similar prohibition regarding the recipient. Such disclosure is unlawful, unless the recipient has consented thereto in writing. If the recipient has died without giving consent or without having indicated that he would not be prepared to give such consent, consent may be given by one of the following persons: a spouse or a major child or a parent or a major brother or a major sister of the recipient (s 33).

It must be noted that the unlawful disclosure of identity constitutes a punishable offence.

(v) Exclusion of civil and criminal liability

The Act exempts from civil and criminal liability a doctor who, for any of the purposes stated in the Act has, in good faith, removed any tissue from a dead body or from a living donor, in the event of any donation subsequently being found to be legally invalid. The same protection is afforded to a magistrate or medical practitioner who has authorised the removal of tissue (s 35).

(vi) Importing and exporting of tissue

The Act strictly controls the importing and exporting of tissue, dead human bodies, blood and gametes by means of a permit which has to be signed by the Director-General of Health (s 25). If tissue is imported contrary to the provisions of the Act, it must either be destroyed or removed from the Republic at the expense of the importer, or else it is forfeited to the State (in which event it may be destroyed or dealt with in such a manner as the Director-General may deem fit (s 26)). Contravention of these provisions constitutes a criminal offence.

(g) Offences

The Act creates a number of criminal offences which are punishable by a fine of R2 000 or imprisonment for a period not exceeding one year (or both). Amongst the offences are the following:

- (1) acquiring, using or supplying the body of a deceased person, or tissue, blood or a gamete from a living person, in any manner or for any purpose other than is permitted by the Act
- (2) using a gonad in the body of a living person contrary to the provisions of the Act
- (3) removing tissue from the body of a living person, or using or transplanting tissue thus removed, by a person who is not a medical practitioner or a dentist
- (4) disclosing the identity of a donor or recipient of tissue, otherwise than in accordance with the Act
- (5) contravening a provision or condition relating to the importing or exporting of tissue, blood, a blood product or a gamete (s 34)

(h) Diagnostic ("hospital") post mortem examinations

In terms of section 8 of the Act, a *post mortem* examination of the body of a deceased person may be conducted before burial if the deceased gave consent thereto prior to his death, or if the autopsy is necessary to determine more precisely the cause of death, or for a specific scientific purpose. These provisions clearly indicate that consent by the deceased before his death is not an absolute requirement. All that must be established is that the autopsy is in fact necessary for the purpose stated. The Act contains no indication that the deceased's relatives have to be consulted or that they have any right to veto an autopsy.

The provisions of section 14 relating to official authorisation (discussed above) also apply to *post mortem* examinations under section 8, except that the authorising official need not, of course, be satisfied that the deceased's body has been donated for scientific or therapeutic purposes.

Where a (living) person consents to a *post mortem* examination of his body, this consent must be obtained in the same manner as if he were donating his body for scientific or therapeutic purposes.

Note that a *post mortem* examination may be performed only by a medical practitioner personally (see s 8, read with s 14(1)(b)).

6.3.3 No curative purpose

Where the operation is not aimed at healing either the injured or another, the legality of the intervention depends on the question whether the ultimate object is a legally approved one.

6.3.3.1 Pointless operation

A completely pointless operation undertaken in the knowledge that it is unnecessary — which is not without precedent in the medical world — is undoubtedly unlawful. This is so whether the operation is performed for profit or for any other reason, no matter how skilfully it might have been performed, and regardless of whether the patient consents or not.

A German case of 1978 illustrates this principle well. A patient suffered from headaches of unknown origin. To alleviate the pain she asked her dentist to extract all her teeth with fillings. The dentist did not believe that this would in any way benefit her, but took out the teeth nevertheless. He was convicted of “Körperverletzung” (a form of assault). The court ruled that the patient’s consent was null and void because it was based upon a foolish diagnosis made by the patient herself, and a misunderstanding of the underlying illness. See 1978 NJW 1206 (BGH).

6.3.3.2 Cosmetic operation (plastic surgery)

Cosmetic operations with the consent of the patient cannot be regarded as unlawful, unless the operation constitutes a threat to the patient’s life or health. Even serious cosmetic operations seem to be justifiable where it is deemed necessary for the psychological benefit to the patient; such operations are in fact then of a therapeutic nature. An example would be drastic cosmetic surgery to the face of a patient to remedy highly unsightly disfigurement resulting from an accident, an assault or burns.

6.3.3.3 Castration

Non-therapeutic castration (the surgical removal of the testicles) can hardly ever be considered lawful. It is a well-known fact that 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 authorities even connived to permit this practice. The last of the famous *castrati* singers was apparently still active on the stages of Italy during the first quarter of the twentieth century.

The Swiss author Noll (97) is of the opinion that castration may be justifiable where it is the only means of preventing a sexual offender from committing further crimes after psychotherapy had been fruitless. With the possible exception of the case just mentioned, and in view of the drastic effects of such an operation on the body and mind of the injured person, castration should be treated as an aggravated assault.

In Germany there is statutory provision for voluntary castration (the Act of 15 August 1969). The Act was intended to be a provision against the effects of an inordinately strong sexual urge. Particularly strict requirements were laid

down, *inter alia* that the castration must be aimed at curing the person of serious deviations, psychological disturbances or suffering, or at alleviating his suffering. He must be at least 25 years old and must consent to the castration. See Deutsch 210; Laufs A *Handbuch des Arztrechts* 3 ed (2002) 1072–1076.

Certain remarks by our Appellate Division in *S v V* 1972 (3) SA 611 (A) may be of importance here. The accused, a 20-year-old youth, was sentenced to death after being found guilty on five counts of rape and (*inter alia*) five lesser counts in connection with sexual offences. He applied to the Appellate Division for leave to appeal against his sentence and at the same time to submit new evidence, *inter alia* concerning the possibility of undergoing brain surgery in order to destroy or diminish his sexual urge. The Appellate Division, however, refused to grant the application to submit further evidence. Jansen JA stated as follows:

Assuming [the evidence] to establish the possibility of complete rehabilitation, a court would not be entitled to impose a shorter sentence of imprisonment than it would otherwise have done, merely because of a possibility which has not yet received general acceptance in the field of penology. Moreover, our criminal procedure does not provide a court with the means to enforce or control such drastic methods of rehabilitation. Even the consent of the applicant to such an operation does not remove the many legal, moral and practical difficulties involved. A court would certainly not, at this early stage in this particular field of surgery and psychiatry, bring pressure to bear upon an accused to undergo such operation, by way of, eg suspending any sentence upon appropriate conditions. Moreover, in the case of the applicant, on the evidence as it stands, it has not been established that the appellant's conduct is to be attributed primarily to an overpowering sexual drive; on the contrary, Dr F considered the appellant's conduct to be largely involved with a desire to be revenged upon society and to humiliate women, and he was not prepared to concede that it flowed primarily from any physiological, sexual basis.

On general considerations, however, the death penalty was set aside by the majority of the judges and replaced with a long term of imprisonment. The considerations in regard to the proposed brain surgery would have applied equally if castration had been at issue.

There is a tragic footnote to the case of V: In 1987 he was released. During the first days of 1989 he raped two women, one of whom he stabbed with a knife and killed; his other victim shot and killed him with his own firearm.

Castration will be permissible in the following situations:

- (1) Where a child is born with the sexual organs of both sexes. Such a person is known as a hermaphrodite. In such a case the child's parents may for example decide that the male organs be removed to allow the child to grow up as a female.
- (2) A so-called transsexual who has the sexual organs of a male but is psychologically oriented as a female, may wish to be surgically "converted" into a female. In such cases there may be a therapeutic

objective, seen from a psychological perspective. See our discussion of transsexualism and so-called “sex change” operations below.

- (3) There may be a sound medical reason for castration, for example where a man is diagnosed with testicular cancer. In such a case the operation will, of course, be performed with a therapeutic objective.

It is to be noted that the surgical removal of the testicles must be distinguished from so-called “chemical castration”, in other words, the administration of a drug which inhibits both sexual performance and desire. The drug used is an anti-androgen, used in female contraceptives, the treatment of prostate cancer and the treatment of acne. It also blocks the male hormone testosterone which is produced in the testicles. Its effect on the suppression of sexual desire is reversible once the administration of the drug is stopped.

In 2003 a Durban magistrate sentenced a convicted paedophile *inter alia* to chemical castration. The accused pleaded for the castration in mitigation of sentence. The prosecutor contended that castration would fail to treat the psychological roots of sexually deviant behaviour (*Legalbrief News Diary* 28 October 2003).

6.3.3.4 Sterilisation

(a) General

Until the middle of the twentieth century sterilisation for convenience, that is to prevent the birth of a child, or of more children, was frowned upon socially in many countries. Thus in *Bravery v Bravery* [1954] 2 A11 ER 59 Denning LJ in a dissenting judgment declared that the mere objective “to have the pleasure of sexual intercourse without shouldering the responsibilities attaching to it” rendered sterilisation unlawful.

Where, on the other hand, the objective was medical or eugenic, such as prevention of the transfer of a hereditary disease, the juristic attitude was more favourable. Thus sterilisation of mentally feeble or disordered persons was expressly legalised by statute many years ago in a number of American states. See Williams 84.

Today it is generally accepted in Western Europe and the USA that voluntary sterilisation is lawful in principle. See Deutsch 209. The same applies to South Africa. See *Edouard v Administrator of Natal* 1989 (2) SA 368 (D). Section 12 of our Constitution guarantees the right, *inter alia*, of everyone to make decisions concerning reproduction, which without a doubt includes the right to have yourself sterilised. Most of the world is in the grip of a population explosion, and family planning is regarded in many societies as laudable. In mainland China the law actively discourages families from having more than one child.

Sterilisation in South Africa is governed by the Sterilisation Act 44 of 1998. “Sterilisation” is defined as “a procedure whereby a person could be permanently rendered incapable of fertilisation or reproduction” (s 1 of the Sterilisation Act 44 of 1998).

(b) Persons capable of consenting

A person may be sterilised if he or she is

- (i) capable of consenting
- (ii) 18 years or above (s 2(1))

Such a person may not be sterilised without consenting (s 2(2)).

The Act leaves no doubt that an **unmarried** person of 18 years or above may also be sterilised.

Sterilisation may not be performed on a person who is **under the age of 18 years**, except where failure to do so would jeopardise the person's life or seriously impair his or her health (s 2(3)(a)). In the case of a youth under 18 years, a request must be made to the person in charge of a hospital, and the consent of the youth's parent, spouse, guardian or curator is required (s 2(3)(b) read with s 3(1)(a)). The person in charge of the hospital must, upon request (as prescribed by the regulations under the Act) convene a panel consisting of a psychiatrist or medical practitioner if no psychiatrist is available, a psychologist or a social worker, and a nurse (s 2(3)(b) read with s 3(2)). A youth under 18 years may be sterilised if consent is given by a person who is lawfully entitled to give consent, and an independent medical practitioner who, before a panel is convened in terms of section 3(2), has consulted with the youth to be sterilised and has provided a written opinion to the effect that the sterilisation is in the best interest of the youth (s 2(3)(c)).

The panel has to consider all relevant information, and has to concur that a sterilisation may be performed on the person (s 3(1)(b)). "Relevant information" includes the person's (the youth's) age; whether there are other safe and effective alternatives to sterilisation; the person's mental and physical health and wellbeing; the potential effect of sterilisation on the person's mental and physical health and wellbeing; the nature of the sterilisation procedure to be performed; the likelihood that the person will become capable of consenting to sterilisation; whether the sterilisation is in the best interests of the person to be sterilised; and the benefit which the person may derive from sterilisation (s 3(1)(b)).

A contravention of these provisions constitutes a serious criminal offence (s 9). It may incur a sentence of up to five years' imprisonment.

(c) Persons incapable of consenting or incompetent to consent due to mental disability

A sterilisation may be performed on a person who is **mentally disabled** to such an extent that he or she is incapable of

- (i) making his or her own decision about contraception or sterilisation
- (ii) developing mentally to a sufficient degree to make an informed judgement about contraception or sterilisation
- (iii) fulfilling the parental responsibility associated with giving birth (s 3(1)(c))

"**Mental disability**" means "a range of functioning extending from partial self-maintenance under close supervision, together with limited self-protection skills in a controlled environment through limited self care and requiring

constant aid and supervision, to restrained sensory and motor functioning and requiring nursing care” (s 3(7)).

In the case of such persons sterilisation may only be performed on a request made to the person in charge of a hospital, and with the consent of a parent, spouse, guardian or curator of the patient (s 3(1)(a)). A panel, constituted as described above, must be convened. It must consider all relevant information as described above. The panel must concur that the procedure may be performed. (Note that if the patient is in custodial care, no member of the panel may be an employee of the custodial institution (s 3(3)). If the sterilisation is to be performed in a private health-care facility, the members of the panel may not be employees of, or have a financial interest in, that facility (s 3(4)).)

The persons performing the procedure must ensure that the method of sterilisation used holds the least health risk to the person on whom the sterilisation is performed (s 3(5)).

(d) Consent

For the purposes of the Sterilisation 44 of 1998 Act “consent” means consent given freely and voluntarily without any inducement (s 4). The patient (or other person giving the required consent, such as a parent in the situations described above) must have been given a clear explanation and adequate description of

- (i) the proposed plan of the procedure
- (ii) the consequences, risks and the reversible or irreversible nature of the sterilisation procedure

The person whose consent is sought must have been given advice that the consent may be withdrawn any time before the treatment. Consent must be given by way of signing the consent form as described by ministerial regulations under the Act. It is expressly required that the person giving the consent must have understood the prescribed consent form.

Consent in terms of the Act therefore implies a fully informed consent. The question arises as to whose duty it is to inform the patient. It will clearly be advisable for the doctor performing the procedure to do so himself, but a practitioner is entitled to delegate his duty to a responsible person, such as a nurse. However, in the event of insufficient information being given — resulting in flawed consent by the patient — it will be the doctor who may be legally accountable.

Must all the possible consequences and risks of the procedure be explained to the patient? To require that would clearly be unreasonable. We are of the opinion that the common-law criteria as to the amount of information to be imparted will probably be applied by the courts in the event of a dispute (see our discussion of consent in study unit 5 above).

As far as married persons are concerned there is no indication whatsoever in the Act that in the case of a spouse who is capable of consenting and seeks sterilisation, and is 18 years or older, the consent of the other spouse is also required.

Earlier in the previous century there was strong support for the view that where a spouse was sterilised, it was necessary to obtain the consent also of the other spouse. This view proceeded from the premise that there was a “mutual right to procreate” within the normal marriage. However, there is very little support for this view today. The modern view is that each spouse is autonomous as far as his or her body is concerned (see Sonnekus JC “Sterilisasie — toestemming deur nie-pasiënt-gade?” 1986 DR 369). Section 12 of the Constitution to which we referred above, supports this view.

In *Raath and Another v Mukheiber* 1999 (3) SA 1065 (SCA) the court intimated by means of a rhetorical question that a spouse has full autonomy regarding a sterilisation operation.

(e) Miscellaneous provisions

Sterilisation of persons incapable of consenting or incompetent to consent due to mental disability may be performed only at a facility designated in writing for that purpose by the member of a provincial Executive Council responsible for health (s 5).

The person in charge of such a facility must be notified of all sterilisations performed there, and must keep adequate records (s 6).

As we have mentioned above, non-compliance with the Act will constitute a serious criminal offence (s 9).

(f) Failed sterilisation or sterilisation not performed: “pregnancy claims”

A discussion of sterilisation would be incomplete without some reference to liability flowing from failed sterilisation or failure to perform a sterilisation. Over approximately the past three decades a number of cases have come before the courts — particularly in the USA — involving allegations of medical negligence in respect of contraception, sterilisation, genetic screening and abortion, which resulted in the birth of an unwanted child — a child which, in addition to being unwanted, in some cases was also seriously handicapped. Various labels were attached to this type of case.

In the USA, courts initially held that a doctor would not be held liable for negligence in the performance of sterilisation operations which resulted in the birth of an unwanted, normal child, on the ground — as it was put in a 1957 case — that “to allow damages for the normal birth of a normal child is foreign to the universal public sentiment of the people” (*Shaheen v Knight* 11 D & C 2nd 41 (1957)).

Later the judicial outlook changed, and doctors were held liable in some cases of this nature. Generally speaking courts were prepared, in cases of proven negligence on the part of the doctor (eg in performing a sterilisation, or in failing to advise genetic screening of a pregnant women, or in failing to advise her to have the pregnancy terminated) to order the doctor to pay damages in the form of medical expenses in connection with the birth of the child. In exceptional cases the doctor was held liable for maintenance of the child, but usually the courts were not prepared to go to such an extreme.

There have been several such cases in **England** since 1980. In some of these

cases the plaintiffs have succeeded in recovering damages and in other cases their claims have failed. It is difficult at this stage to extract hard-and-fast rules from the English cases. Only two of these cases will be discussed here; both are decisions of the Court of Appeal.

In *Thake and Another v Maurice* [1986] 1 All ER 497 (CA) a married man underwent an unsuccessful vasectomy and a sixth child was born to his wife and himself. The couple instituted an action for damages against the medical practitioner who had performed the vasectomy. The plaintiffs' action (which was successful) was based on negligence on the grounds of the practitioner's failure to comply with a contractual agreement, and to exercise a delictual duty to take care, in that the medical practitioner had failed to warn them that the husband could again become fertile. The Court held that the plaintiffs were entitled to damages for prenatal stress, pain and suffering as well as the reasonable cost of rearing the unplanned child. A total amount of £11 177 in damages was awarded.

In *Eyre v Measday* [1986] 1 All ER 488 (CA) a woman who had undergone a sterilisation operation nevertheless gave birth to a child. She could not prove that the operation had been performed negligently, nor did she allege that the doctor ought to have warned her that the operation may have been unsuccessful. Accordingly her claim was rejected.

The first decision on "wrongful conception" in **South Africa** was handed down in *Behrmann and Another v Klugman* 1988 (4) SA Practice Management 6 (W). In that case Mr and Mrs B sued Dr K, a specialist surgeon, for a total of R299 609 damages in consequence of the birth of a normal child who had been conceived following a vasectomy performed by the doctor on Mr B. The plaintiff's action was based on alleged breach of contract on the part of the doctor, and alternatively, negligence. The plaintiffs alleged *inter alia* that there had been an express or implied agreement that the doctor would properly and skilfully carry out the vasectomy, taking all necessary precautions to ensure that the vasectomy rendered Mr B permanently sterile, and to prevent recanalisation of the *vas deferens* (sperm duct). It was contended by the plaintiffs that the doctor had failed to advise Mr B to have a sperm count before intercourse without contraception was resumed. The doctor denied that he had breached the agreement or had been negligent.

The decision in the *Behrmann* case essentially turned on whether the plaintiffs had been adequately warned about the necessary sperm counts in order to establish infertility. The plaintiffs testified that statements made by the doctor had caused them to believe that the operation was irreversible and would render Mr B sterile after ten weeks. Dr K testified, however, that it was his practice to tell patients that it would take up to nine months to achieve two negative sperm counts, and that he would first have to declare the husband sterile. Melamet J found in favour of the doctor. The judge found on the evidence of the plaintiffs that they had in fact waited sixteen to twenty weeks after the operation before commencing intercourse without contraceptives. Accordingly the judge had grave reservations whether Mr and Mrs B had in fact believed that Mr B would be sterile after ten weeks.

The court agreed with the view expressed by the English Court of Appeal in *Eyre v Measday* that in the absence of an express warranty, the court should

be slow to imply that a medical man gives an unqualified warranty regarding the results of an intended operation. Melamet J concluded that Mr and Mrs B, on a balance of probabilities, had failed to establish that the contract between them and Dr K contained an express or implied term or warranty regarding the permanent success of the operation.

In the light of the grounds on which the plaintiffs' action was dismissed, the decision left open the question whether such an action is not *contra bonos mores*.

In a comparable case, *Edouard v Administrator of Natal* 1989 (2) SA 368 (D), the verdict went in favour of the parents of a child. In that case the parents had agreed with a provincial hospital that a tubular ligation would be performed on the woman at the time of giving birth by Caesarean section to her third child. The hospital staff failed, however, "to cause the said surgery to effect the tubular ligation of the [woman's] fallopian tubes, to be performed at all".

The woman and her husband believed that the sterilisation procedure had been performed, and accordingly took no precautions to use any contraceptive methods to prevent pregnancy. Approximately four months after the birth of her third child the woman fell pregnant again. She gave birth by Caesarean section to a normal child, and a tubal ligation was then performed on her by Dr F.

The child's father brought action against the Provincial Administrator in his capacity as the executive of the Provincial Administration for damage allegedly suffered in consequence of breach of contract. The defendant conceded that the administration was liable for damages for breach of contract as a result of its failure to effect the tubular ligation that had been agreed upon, and contended that payment of the cost of the surgery (R622,79) subsequently performed by Dr F would discharge its liability. (A factor in this case, it is to be noted, was that the defendant had also conceded that the woman had requested the procedure because she and her husband could not afford to support any more children.)

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

- (1) general damages for the discomfort, pain and suffering, and loss of amenities suffered by his wife (with whom he was married in community of property and on whose behalf he sued)
- (2) the cost of maintaining the child until she attains the age of 18 years

The defendant denied liability for such further compensation on the grounds that although the contract for the woman's sterilisation was valid and enforceable, it would be contrary to public policy to allow the parents of a healthy and normal but unplanned child to recover the cost of bringing up the child where the parents refuse to give the child out for adoption.

Council for the defendant argued that it was the notion that the court, in assessing "damages" of this nature, was called upon to decide whether a value or no value in monetary terms should be given to a healthy life, an action that was offensive in the light of the South African view of the sanctity of life "in the context of our anti-abortion laws". The cost of maintaining a child, it was

submitted, was “but one of the incidents of parenthood — that Pandora’s box of joy, expectation, disillusionment, worry, expense and resignation and hopefully, in old age, reward”.

The court held, however, that damages in the form of **maintenance** for the child were recoverable. Sterilisation, according to the judge, has become an accepted form of contraception for married couples. “It is in the interest of society that the size of a family should not exceed the limit beyond which it would not be possible to maintain a reasonable standard of living.”

The judge went on to say that there would be nothing inconsistent in the attitude of the parents if they were to say that they had not wanted another child, but now that the child had been born, they loved it and refused to part with it. The acceptance of the responsibilities of parenthood, however, would still leave the parents in the dilemma which they had wanted to avoid by means of the sterilisation, that is that they have a child whom they are unable to support.

The loss which the parents complained of was an economic loss which cannot and need not be weighed against the value of the life of a child. The emotional benefits which the birth of the child bestowed on the parents do not increase their patrimony, and are irrelevant in the determination of the *quantum* of damages.

Thirion J continued as follows:

It would be fair and equitable that liability to provide for the maintenance of a child should fall on the doctor through whose neglect it was born, rather than that it should fall on the parents, who because of their inability to provide adequately for the child had not wanted to have it. Fathers are regularly ordered by the courts to bear the cost of maintaining their illegitimate offspring. It would be a novel argument for the father of such a child to claim that by fathering a child he had conferred a benefit or a blessing on the mother which outweighs the cost of maintaining the child.

The court regarded the argument that it is morally wrong that a normal healthy life should be the basis of a compensable wrong as “squeamish and pedantic”. Compensation would not be awarded for the fact that a child was allowed to be born. It would be awarded for the loss which the parents would suffer in having to support the child whose conception the doctor had negligently failed to avoid, and whom they would not be able to support.

No court would require parents to mitigate their loss by having the child adopted. An innocent party who has suffered loss as a consequence of breach of contract had only to take reasonable steps to mitigate his loss. To require that parents should give away their child would not be reasonable. That would run counter to our accepted community values.

The judge felt that although the assessment of damages in wrongful birth actions can raise difficulties, those difficulties are not by any means insurmountable.

The fears that imposition of liability would lead to awards of damage quite disproportionate to the moral culpability of the doctor, or might tend to warp

professional standards in that doctors might be tempted to improperly advise patients to have abortions or make practitioners unwilling to undertake sterilisation operations, were exaggerated in the judge's opinion.

He added that the operation is a fairly simple procedure, and that it would be a simple matter for the doctor to explain to the patient that there is, despite the operation, a possibility that she might still fall pregnant. It would be easy for the doctor to contract out of liability.

In the event the court came to the conclusion that **it would not be contrary to public policy to recover damages in respect of the child's maintenance**. The defendant was accordingly ordered to pay R22 500 to the plaintiff, the amount on which the parties had agreed.

The court was **not prepared, however, to award general damages for the woman's pain and suffering, etcetera**. "The question whether liability on **contract** for damages should be extended so as to cover damages for non-pecuniary loss flowing from the breach of the contract, involves considerations of legal policy," the judge said. In view of the ease with which a delictual claim — that is an action based on a civil wrong, for which general damages may be claimed — can be conjoined with a contractual claim, the judge saw no real need for extending liability to contract for that kind of loss. **In this case a delictual claim was not so conjoined** because the plaintiff had failed to give timeous notice of his intention to bring such an action, as is statutorily required.

It is to be noted that, for the sake of convenience, the court used the term "wrongful birth" to describe this type of case. Legal terminology has not yet been quite settled, however. The following terms seem to have gained fairly general acceptance in American literature:

- (1) "wrongful pregnancy" or "wrongful conception" for cases where a **healthy** child is born, following negligent contraceptive advice or a negligent sterilisation or abortion operation, 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

Edouard's case was taken **on appeal** and the judgment of the court *a quo* was **confirmed unanimously** by a five-judge bench of the Appellate Division in *Administrator of Natal v Edouard* 1990 (3) SA 581 (A). In his judgment Van Heerden JA drew attention to the fact that the case was **unique** in the sense that it was based upon a **complete failure to perform a sterilisation procedure as agreed upon**. As far as terminology was concerned the judge preferred the simpler designation of a "pregnancy" claim.

The Appellate Division dealt at length with the argument that as a matter of law the birth of a normal child is such a blessed event that the benefits flowing from parenthood cancel or outweigh the financial burden brought about by the obligation to maintain the child. It was argued before the court that the birth of a normal child cannot be treated as a wrong against his parents. The judge said that the concise answer to that "is that the 'wrong' consists not of

the unwanted birth as such, but of the prior breach of contract (or delict) which led to the birth of the child and the consequent financial loss”. Van Heerden JA made the following observation:

I do not find attractive the proposition that the birth of a normal child is a blessing which in law cannot constitute a wrong. Parents who cannot afford a further child may well be overjoyed by the birth of another, but unwanted, sibling, but will naturally be dismayed by the additional financial burden cast upon them. It is, after all, that burden and not the child as such which is unwanted.

He said that the birth of a normal child does not invariably constitute a blessing, and that “the child may turn out to be a drug addict or violent psychopath”.

The court also responded to the argument that it would be highly undesirable for a child to learn in his later life that a court had publicly awarded damages to his parents because his birth was a mistake. On this Van Heerden JA had the following to say, *inter alia*:

Once parents decide to keep the child and not to put him out for adoption, the child is no longer unwanted. What remains unwanted, is the additional financial burden caused by his birth. Should the child learn that his birth was a mistake, what will matter to him is not why he was born, but how his parents subsequently cared for him.

The main submission of counsel for the appellant was that it was against public policy that the basic legal duty of parental support be transferred to the hospital authority. This, it was argued, would interfere with the sanctity accorded by law to the parent-child relationship. The Appellate Division regarded his contention as basically fallacious. The judgment in favour of the child’s father — in so far as the sum of R22 500 was awarded — in no way relieved himself or his wife from the obligation to support the child. Accordingly there was **no transfer** of that obligation. Should the money be lost for some reason, the father would remain obliged to support the child “from such other sources as he may be able to muster”.

The Appellate Division further held that the father’s pregnancy claim had rightly been allowed by the court *a quo*. An important **qualification** was added to this finding by the court, namely that **this conclusion was “intended to pertain only to a case where, as here, a sterilisation was performed for socio-economic reasons”**.

As far as the father’s claim for damages for discomfort, pain and suffering, and loss of amenities of life experienced by his wife in consequence of her pregnancy and confinement was concerned, the Appellate Division also **confirmed** the judgment of the trial court that **an intangible loss cannot be recovered in contract**. Only patrimonial loss may be recovered.

The *Edouard* decision leaves little doubt that in South Africa liability will arise in (1) the “classical” situation of “wrongful conception” (pregnancy resulting from medical negligence in respect of sterilisation where a normal child is born), as well as (2) the situation of “wrongful birth”, that is where it

is alleged that the birth of a defective child should have been medically prevented by means of, for example, a lawful abortion.

“Wrongful birth” as a cause of action was upheld in principle in *Friedman v Glicksman* 1996 (1) SA 1134 (W) in exactly that situation. The plaintiff, a woman, alleged that the defendant, a gynaecologist, had negligently failed to diagnose a severe defect in her unborn child and to advise her to have her pregnancy terminated. The court held that the plaintiff was entitled to recover damages in this case. Because this case concerns **abortion and not sterilisation**, it is discussed in greater detail below. We mention it here, however, because “**wrongful birth**” liability may clearly also arise in consequence of a sterilisation performed negligently or not at all.

The majority of Western jurisdictions have so far refused claims for “wrongful life” in the narrow sense, that is where a suit for damages is brought on behalf of the impaired infant rather than the parents. As we shall see below, the claim was also refused by the Witwatersrand court in the *Friedman* case. In the latter type of claim the child does not allege that the doctor caused the impairment, but that he (the doctor) was responsible for the child’s very existence. Different policy considerations may apply in respect of such a claim. It is life itself that is construed as harm (Botkin JR “The legal concept of wrongful life” 1988 *JAMA* 1541; see also Boberg PQR “An action for wrongful life” 1964 *SALJ* 498; Brownlie S “Wrongful life: is it a viable cause of action in South Africa?” 1985 *Responsa Meridiana* 18; Louw PF “‘Wrongful life’: ’n aksie gebaseer op die onregmatige veroorsaking van lewe” 1987 *TSAR* 199; Blackbeard M “Die aksie vir ‘wrongful life’: ‘to be or not to be?’” 1990 *THRHR* 57; Pearson FL “Liability for so-called wrongful pregnancy, wrongful birth and wrongful life” 1997 *SALJ* 91.

Before ending our discussion under this heading, reference should be made to an unusual South African case in which a doctor was sought to be held liable on the basis that he had made a misrepresentation relating to the sterilisation of a woman. The case is *Raath and Another v Mukheiber* (1997 CPD unreported).

In this case a married woman and her husband claimed damages from a gynaecologist after the woman had given birth to a **normal** child. The allegation was made that the doctor had delivered the woman’s previous child by means of Caesarean section, and when he removed the operation stitches shortly afterwards, told the woman and her husband that he had performed a sterilisation operation on her. (The doctor, when removing the stitches, allegedly told the woman that she was now a “sports model”.) As a result of the doctor’s statement the couple did not use contraceptives, and another child was conceived and born in due course.

It was common cause that a sterilisation was never done by the doctor. It was further common cause that when the Caesarean section was decided upon, the question of the doctor performing a sterilisation upon the woman was discussed. The doctor advised her to discuss this matter with her husband, as he regarded the latter’s consent as necessary. No discussion as proposed by the doctor took place, however, and it was never agreed by the parties that Dr M would perform a sterilisation procedure. In court Dr M denied that he had ever told Mrs R and her husband that he had sterilised her.

On the evidence before it the court on appeal found that the plaintiffs had discharged the onus of establishing that the doctor had made the alleged misrepresentation. Since the question of sterilisation originally arose because of the plaintiffs' financial inability to afford further children, the court held that the plaintiffs were entitled to recover damages.

The decision of the court of appeal was upheld by the Supreme Court of Appeal in 1999. The court ruled that the plaintiffs were entitled to be compensated by the doctor for a **pure economic loss**, in respect of (1) confinement costs, and (2) maintenance of the child until it becomes self-supporting. The court further made the following important statement: **In a delictual action of this nature, the claim for damages is not limited only to the situation where the request for sterilisation was made for socio-economic reasons** (par 48 of the judgment reported as *Raath and Another v Mukheiber* 1999 (3) SA 1065 (SCA)).

May a doctor protect himself against this form of liability by insisting that the parents of the child pre-operatively sign a **disclaimer** (waiver) agreement? (This is done generally in practice today.) In *Edouard* (1989 (2) SA 368 at 385E) the court *obiter* seemed to suggest that it was possible. But *Edouard's* case did not pertain to negligence; the claim was based on breach of contract. The question to be answered is whether an indemnity against liability for negligence will not be *contra bonos mores*. See our discussion, below, in par 9.3.6.

ACTIVITIES

1. Explain the difference, if any, between active euthanasia and passive euthanasia. Your answer should include an example.
2. Explain the legal limitations applying to removal of tissue from the body of a living person for purposes of transplantation into the body of an ailing person.
3. Discuss the lawfulness or otherwise of the operation of castration.
4. Mrs Y is pregnant with her third child. She and her husband decide not to have any more children. Dr X will attend to the delivery of the baby by way of Caesarean section. Mr and Mrs Y request Dr X to effect a sterilisation operation upon Mrs Y at the time of delivery of the baby. Mrs Y nevertheless falls pregnant again, about three months after the birth of the child. A physically handicapped child is subsequently born. Would Mr and Mrs Y be entitled to sue Dr X for damages?

FEEDBACK

1. "Active" euthanasia refers to an act of intentional mercy-killing which still constitutes murder in South African law. "Passive" euthanasia, on the other hand, refers to a situation where a very sick and sometimes aged person is virtually dying already and where the doctor and relatives of the patient agree "to stand back" and let nature run its course. Ethical, religious and philosophical considerations play a role in deciding upon the legality of passive euthanasia.

The leading case in South Africa is *Clarke's* case which is authority for the proposition that in extreme cases of illness, where the patient is moribund, medical treatment may be discontinued.

2. The Human Tissue Act 65 of 1983 allows such transplants within fairly wide limitations. Even a kidney may be donated by a living person. But there are certain restraints built into the Act to protect minors and mentally ill persons. See part 6.3.2.1 of our discussion above.
3. Generally speaking the law frowns upon castration not performed for therapeutic reasons, for example where a patient has been diagnosed with cancer of the testicles. But castration can be performed in exceptional cases, such as on transsexuals (with a view to “sex change”) or hermaphrodites. See our discussion in part 6.3.3.3 above.
4. The first issue to be cleared up is whether there has been negligence on the part of Dr X, for example that he has forgotten to perform the sterilisation operation, or has not made a “proper job” of it. If such negligence can be proved, Mr and Mrs Y will have an action for damages for so-called “wrongful birth”. Damages may include the cost of Mrs Y undergoing another sterilisation operation and, importantly, also the expenses they will incur in raising the unfortunate child, as well as future medical expenses necessitated by the disability of the child. The leading South African case is that of *Friedman v Glicksman* (discussed by us in detail above). Please refer to this case should you still be unsure about this question.

STUDY UNIT 7

Legally recognised medical procedures (continued)

Contents

- 7.1 Introduction
 - 7.2 Abortion
 - 7.2.1 Introduction
 - 7.2.2 Values recognised
 - 7.2.3 When may pregnancy be terminated?
 - 7.2.4 The first 12 weeks
 - 7.2.5 From 13 to 20 weeks
 - 7.2.6 After the 20th week
 - 7.2.7 Method of termination
 - 7.2.8 Place where termination may take place
 - 7.2.9 Counselling and informing woman
 - 7.2.10 Consent requirements
 - 7.2.11 Notification and keeping of records
 - 7.2.12 Criminal abortion
 - 7.2.13 Power of courts to interfere
 - 7.2.14 Choice on Termination of Pregnancy Amendment Act 38 of 2004 unconstitutional
 - 7.2.15 Civil liability for negligent abortion or failure to perform abortion
 - 7.2.15.1 “Wrongful life”
 - 7.2.15.2 “Wrongful birth” and “wrongful pregnancy”
 - 7.3 Scientific experimentation
 - 7.4 Artificial insemination
 - 7.4.1 Introduction
 - 7.4.2 Statutory regulation
 - 7.4.3 The legal position of the AID child
 - 7.4.4 The potential liability of the doctor
 - 7.5 Embryo transfer, *in vitro* fertilisation (IVF) and surrogate motherhood
 - 7.5.1 Embryo transfer
 - 7.5.2 *In vitro* fertilisation (IVF)
 - 7.5.3 Surrogacy agreements and legal status of the child
 - 7.5.4 Experimentation on embryos
 - 7.6 “Sex change” (Transsexualism or Intersexuality)
 - 7.7 Genetic engineering
 - 7.7.1 Introduction
 - 7.7.2 Gene therapy
 - 7.7.3 Genetic counselling
 - 7.7.4 Human Genome Project
 - 7.7.5 DNA typing (“fingerprinting”)
 - 7.7.6 Cloning
- Activities
Feedback

Learning outcomes

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

- understand the legal principles which apply to additional therapeutic and non-therapeutic medical procedures governed by statutory law in South Africa such as abortion, artificial insemination and *in vitro* fertilisation
- explain the general legal considerations applying to scientific experimentation involving human subjects — something that has been part and parcel of the evolution of medical science through the ages — as well as very recent forms of medical innovation such as stem-cell research
- discuss legal aspects pertaining to relatively recent developments in the field of human genetics, in particular genetic engineering, the Human Genome Project, DNA typing or “fingerprinting” and the very controversial subject of human cloning

7.1 Introduction

This chapter is a continuation of our discussion of legally recognised medical procedures, which really forms the bulk of this study guide. We commenced our study of medical law by reflecting on the Constitutional provisions relating to our subject. Then we looked at the basic organisation of the South African health-care system, the regulation of the medical profession by the law, the contractual principles applying to doctor and patient and to doctors mutually, and the important question of the basic legal justification for medical interventions. In study unit 6, we embarked on a consideration of specific types of medical procedures, and the present study unit is a continuation of that discussion.

7.2 Abortion

7.2.1 Introduction

The legality of abortion (or it is perhaps better to say, the limits within which abortion ought to be lawful) is still one of the most controversial issues of our times.

At the one extreme there is the view, based on religious principles, that abortion amounts to murder of the unborn and is never justified. At the other extreme there is the view that the woman is autonomous as far as her own body is concerned, and that the embryo or foetus is part of her body with which she can freely do as she wishes. Between these two extremes there is a wide variety of views on the limits within which abortion may be or ought to be justifiable.

In Roman-Dutch law abortion was legal in a single instance only, namely if continued pregnancy threatened the woman’s life. In 1975 the legislature extended lawful abortion to include six additional grounds or “indications” with the promulgation of the Abortion and Sterilisation Act 2 of 1975. The Act set strict requirements for pre-abortion enquiry, certification and official authorisation.

In many countries of the world, particularly in the West, the twentieth century has seen the societal attitude towards abortion become far more lenient. This also happened in South Africa when the Choice on Termination of Pregnancy Act 92 of 1996 was put into effect on 1 February 1997 and the Abortion and Sterilisation Act 2 of 1975 was repealed.

In *Christian Lawyers Association of SA and Others v Minister of Health and Others* 1998 (4) SA 1113 (T) the court upheld the constitutional validity of the Choice on Termination of Pregnancy Act 92 of 1996. The plaintiffs had alleged that the Act was in conflict with section 11 of the Bill of Rights which provides: “Everyone has the right to life.” They contended that the life of a human being starts at conception and that abortion terminates the life of a human being. The court held that the answer to the question whether the word “everyone” applies to an unborn child does not depend on medical or scientific evidence as to when the life of a human being commences. Nor is it the function of a court to decide the issue on religious or philosophical grounds. The court found that the status of the foetus under common law, particularly regarding the question whether it is a legal *persona*, is uncertain. Had the drafters of the Constitution wished to protect the foetus in the Bill of Rights, one would have expected this to have been done in section 28, which specifically protects the rights of the child, the judge said. Moreover, if section 11 were to be interpreted as offering constitutional protection to the life of a foetus, far-reaching and anomalous consequences would ensue. Abortion would be constitutionally prohibited even if the pregnancy constituted a serious threat to the life of the mother, or where, for example, the pregnancy resulted from rape or incest. “The drafters of the Constitution could not have intended to contemplate such far-reaching results without expressing themselves in no uncertain terms,” McCreath J said.

7.2.2 Values recognised

In the preamble to the Act, the following values, *inter alia*, were said to be given recognition: human dignity, the achievement of equality, security of the person, non-racialism and non-sexism, the advancement of human rights and freedoms, the fact that the Constitution protects the right of persons to make decisions concerning reproduction, and to security in and control over their bodies, and the right of persons “to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice”.

The decision to have children, it is stated in the Preamble, “is fundamental to women’s physical, psychological and social health”. Moreover, “universal access to reproductive health care services includes family planning and contraception, [and] termination of pregnancy ...”.

Having said that, the legislature stated its belief “that termination of pregnancy is not a form of contraception or population control”.

The provisions of the 1975 Act are described as “restrictive and inaccessible”. The new Act is designed to afford “every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs”.

7.2.3 When may pregnancy be terminated?

Of vital importance regarding the circumstances in which, and conditions under which, pregnancy may be terminated, is the age of the foetus. The Act distinguishes three different gestation periods:

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

“Gestation period” is defined in section 1 as the period of pregnancy calculated from the first day of the menstrual period which in relation to the pregnancy is the last.

7.2.4 The first 12 weeks

During this period a pregnancy may be terminated upon request. “Woman” is defined as “any female person of any age”. Termination of pregnancy in these cases may be performed either by a medical practitioner, or a registered midwife or registered nurse who has completed the prescribed course (s 2(1)(a) read with s 2(2)).

7.2.5 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** of injury to the woman’s physical health
- (2) if the continued pregnancy will pose a **risk** of injury to the woman’s mental health
- (3) if there is a **substantial risk** that the foetus will suffer from a **severe** physical abnormality
- (4) if there is a **substantial risk** that the foetus will suffer from a **severe** mental abnormality
- (5) if the pregnancy has resulted from rape
- (6) if the pregnancy has resulted from incest
- (7) if the continued pregnancy will **significantly** affect the social or economic circumstances of the woman (s 2(1)(b))

A medical practitioner must, after consultation with the woman, have formed the opinion that at least one of these indications is present. Only a medical practitioner may carry out the termination (s 2(1)(b) read with s 2(2)). “Rape”, it is to be noted, includes so-called “statutory rape”, that is sexual intercourse with a girl below the age of 16 or with a female idiot or imbecile (s 1 read with s 14 and s 15 of the Sexual Offences Act 23 of 1957).

7.2.6 After the 20th week

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

- (1) where continued pregnancy would endanger the woman’s life
- (2) where continued pregnancy would result in **severe** malformation of the foetus
- (3) where continued pregnancy would pose a **risk** of injury to the foetus (s 2(1)(c))

A medical practitioner must, after consultation with another doctor or a registered midwife or a registered nurse, have formed the opinion that at least one of these indications is present. Only a doctor may carry out the termination (s 2(1)(c) read with s 2(2)).

7.2.7 Method of termination

For the purposes of the Act “termination” means the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman (s 1).

7.2.8 Place where termination may take place

The termination of a pregnancy may only take place at a facility which

- (1) gives access to medical and nursing staff
- (2) gives access to an operating theatre
- (3) has appropriate surgical equipment
- (4) supplies drugs for intravenous and intramuscular injection
- (5) has emergency resuscitation equipment and access to an emergency referral centre or facility
- (6) gives access to appropriate transport should the need arise for emergency transfer
- (7) has facilities and equipment for clinical observation and access to in-patient facilities
- (8) has appropriate infection control measures
- (9) gives access to safe waste disposal infrastructure
- (10) has telephonic means of communication
- (11) has been approved by notice in the Gazette by the Member of the Executive Council of the relevant province who is responsible for health (s 3(1))

A health facility that has a 24-hour service and which complies with requirements (1)–(10) above, may terminate pregnancies of up to and including 12 weeks without having to obtain the approval of the Member of the Executive Council (s 3(3)(a)).

7.2.9 Counselling and informing woman

The Act imposes a duty upon the State to promote the provision of non-mandatory and non-directive counselling before and after the termination of a pregnancy (s 4). The Act further imposes a positive duty on the doctor, registered midwife or registered nurse whom a woman requests to terminate a pregnancy, to inform her of her rights under the Act (s 6). Failure or refusal to do so is not *per se* declared a criminal offence by section 10 (“Offences and penalties”) of the Act. Section 10 does, however, make it a criminal offence to prevent the lawful termination of a pregnancy or to obstruct access to a facility for the termination of a pregnancy; such preventing or obstructing may attract a penalty or a fine or imprisonment for up to 10 years.

It is submitted that “preventing” or “obstructing” as envisaged by the Act requires positive conduct going far beyond a mere omission or refusal by a doctor, a midwife or a nurse to inform the woman of her rights. To regard

such an omission or refusal as “preventing” or “obstructing” would in our opinion offend against the rights of freedom of speech and conscience enshrined in the Constitution.

Likewise refusal to perform a termination if required to do so, can in our opinion not be regarded as criminal conduct; there is nothing in the Act to justify such a harsh result. This is probably the reason why no “conscience clause” was embodied in the Act. In case of emergency, a duty arising from common-law or statute (National Health Act 61 of 2003, s 5) may rest on a doctor to come to a woman’s aid despite his or her objections based on religion, conscience or belief. An example of such an emergency would be where a woman were to present at a doctor’s rooms after a “botched” abortion attempted by an unskilled person, as a result of which her life or health is under serious threat. Dada & McQuoid-Mason 73 are of the opinion that doctors and health professionals employed by the state may have to assist with terminations of pregnancy against their conscience, religion or belief where there are no other facilities available.

In our opinion there is no duty on a doctor requested by a woman to perform a (non-emergency) abortion to refer her to another doctor or facility for the performance of the procedure. The Act (s 6) goes no further than to impose a duty on a doctor to inform her of her rights under the Act. In the light of the Constitutional guarantee of freedom of religion, belief and opinion (s 15) and freedom of expression (s 16), the constitutionality of section 6 of Act 92 of 1996 may be doubtful. In *Wooley v Mannered* 430 US 705 (1977) the US Supreme Court held that the freedom-of-thought constitutional provision included both the right to speak freely and the right to refrain from speaking at all.

7.2.10 Consent requirements

Termination of pregnancy can in principle take place only with the informed consent of the woman (s 5(1)). The Act removes any doubt as to whether the woman’s spouse has to consent to the abortion by providing that, save in the case of a severely mentally disabled woman or a woman in a state of continuous unconsciousness, no consent other than that of the pregnant woman shall be required (s 5(2)). Even a pregnant minor’s consent is sufficient, but a duty is imposed upon the doctor, registered midwife or registered nurse (as the case may be) to first advise the minor to consult with her parents, guardian, family members or friends. However, the procedure may not be denied because the minor chooses not to consult them (s 5(3)). “Minor” for the purposes of the Act means a female below the age of 18 (s 1).

In *Christian Lawyers Association v National Minister of Health and Others (Reproductive Health Alliance as Amicus Curiae)* 2005 (1) SA 509 (T) the plaintiff sought an order declaring the definition of “woman” in the Act unconstitutional on the ground that a girl below the age of 18 years is incapable of taking an informed decision whether or not to have a termination of pregnancy which serves her best interest on her own without parental consent. The court declined to rule thus, and upheld the constitutionality of the relevant provisions of the Act.

The consent of the pregnant woman is not required when she is severely mentally disabled or in a state of continuous unconsciousness. In these cases a parent, spouse, legal guardian or (if such persons cannot be found) a personal curator, may request and consent to the termination of her pregnancy up to and including the 20th week of gestation. In the first 12 weeks of gestation, the pregnancy may be terminated upon request; from the 13th up to and including the 20th week, it may be terminated on the grounds set out in 7.2.5 above. An additional requirement is that two doctors, or a doctor and a registered midwife or registered nurse, must have consented to the termination (s 5(4)).

The Act provides for abortion on the sole consent of two doctors, or a doctor and a registered midwife or registered nurse, upon such severely mentally disabled women or women in a state of continuous unconsciousness in the following circumstances: During the period up to and including the 20th week of gestation, the two doctors, or the doctor and the registered midwife or registered nurse, must be of the opinion that (1) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or (2) there exists a substantial risk that the foetus would suffer from a severe physical or mental abnormality. After the 20th week of gestation, they must be of the opinion that the continued pregnancy (1) would endanger the woman's life; (2) would result in a severe malformation of the foetus; or (3) would pose a risk of injury to the foetus. Those health care professionals who have the authority to consent in such cases must first consult the parent, spouse, legal guardian or personal curator, but the termination of the pregnancy shall not be denied if such representative person(s) refuse(s) to consent (s 5(5)).

7.2.11 Notification and keeping of records

A record of termination of pregnancy carried out by a doctor, registered midwife or registered nurse on a woman at any time before the end of the 20th week of the gestation period must be kept by the practitioner concerned. The person in charge of a facility in which surgical terminations take place must be notified of every termination. Within one month details must be mailed confidentially to the head of the relevant provincial Health Department; the name or address of the woman involved may not be included in these details. Only the woman herself is entitled to disclose her identity (s 7).

7.2.12 Criminal abortion

It is a serious offence for a person who is not a doctor, registered midwife or registered nurse to terminate a pregnancy during the first 12 weeks of gestation, and for a person who is not a doctor to terminate a pregnancy after the 12th week. Furthermore, it is a serious offence for any person to terminate a pregnancy or allow the termination of a pregnancy at a facility other than those mentioned under 7.2.8 above. Conviction of these offences may incur a maximum sentence of 10 years' imprisonment (s 10).

7.2.13 Power of courts to interfere

In *G v Superintendent, Grootte Schuur, and Others* 1993 (2) SA 255 (C) it was held that a court of law has no discretion to order an abortion envisaged in terms of the Act then in force not to take place once the statutory provisions had been complied with. In that case the mother of a 14-year-old girl who had been raped, applied in vain for an order restraining an abortion from being performed; all the necessary certification requirements had been complied with.

7.2.14 Choice on Termination of Pregnancy Amendment Act 38 of 2004 unconstitutional

In 2005 the Choice on Termination of Pregnancy Amendment Act 38 of 2004 came into force. Some of the provisions set out above were either amended or inserted through this Amendment Act. The provisions set out above reflect the position as **amended** by the Amendment Act. On 17 August 2006 the Constitutional Court, in *Doctors for Life International v Speaker of the National Assembly and Others* Case CCT 12/05, declared Act 38 of 2004 invalid on the basis that the National Council of Provinces did not comply with its obligation to facilitate public involvement in relation to this Act. The order of invalidity was **suspended** for a period of 18 months to enable Parliament to enact these statutes afresh in accordance with the provisions of the Constitution.

7.2.15 Civil liability for negligent abortion or failure to perform abortion

7.2.15.1 "Wrongful life"

The First South African decision on "wrongful life" was handed down in the case of *Friedman v Glicksman* 1996 (1) SA 1134 (W). In this case the plaintiff, Mrs F, gave birth to a defective child, Alexandra. In suing Dr G, Mrs F made the following allegations: When pregnant, she consulted Dr G, a specialist gynaecologist, to advise her apropos the risk that she might have been pregnant with a potentially abnormal and/or disabled infant. It was understood between Mrs F and the doctor that she wished to terminate the pregnancy if there was any risk greater than the normal risks of the infant being born in an abnormal and/or disabled condition.

The agreement was that the doctor would provide such advice in order that Mrs F might make an informed decision on her own behalf and on behalf of the unborn child, whether to terminate the pregnancy or not. Alternatively it was alleged by Mrs F that Dr G, by virtue of his professional status, had a duty to provide the advice to her in her personal capacity and on behalf of the unborn child for the purpose of making the decision on possible termination.

The doctor, Mrs F alleged further, had carried out certain tests and advised her that there was no greater risk than the normal risk of having an abnormal and/or disabled child, and that it was quite safe to proceed to full term to give birth. His advice, she said, had been erroneous and Alexandra was born disabled. She maintained that in giving this advice, Dr G had acted negligently in a number of respects. Had she received the correct advice, she said, she would have terminated her pregnancy forthwith. She accordingly brought two claims:

- (1) a claim in her **personal capacity** for the expenses of maintaining and rearing Alexandra, as well as for all future medical expenses and hospital treatment and other special expenses
- (2) a claim in her **representative capacity** on behalf of Alexandra for general damages, as well as a claim for future loss of earnings

The doctor argued that it would be against public policy to enforce the contract entered into between Mrs F and himself, “because it would encourage abortion and thus be inimical to the right to life enshrined in the [interim] Constitution ... as well as to the generally recognised sanctity accorded by society to life and the process by which it is brought about”. The judge rejected this argument, though, pointing out that it was contrary to the Abortion and Sterilisation Act 2 of 1975, then in force, which allowed abortion *inter alia* in cases where there was a serious risk that the child to be born would be irreparably seriously handicapped, either physically or mentally.

Goldblatt J went on to say:

Thus the legislature has recognised as do most reasonable people, that cases exist where it is in the interests of the parents, family and possibly society that it is better not to allow a foetus to develop into a seriously defective person causing serious financial and emotional problems to those who are responsible for such person’s maintenance and wellbeing. However, it must be stressed that the election to proceed with or terminate the pregnancy in these circumstances rests solely with the mother who bears the moral and emotional burden of making such election.

In the judge’s view the contract entered into between Mrs F and Dr G was “sensible, moral and in accordance with modern medical practice”. “Wrongful pregnancy” and “wrongful birth” claims are therefore not contrary to public policy. The doctor’s argument that there could be no claim against him since Alexandra’s condition had not been caused by an act or omission on his part but was a congenital defect arising at the time of conception, could not stand, the judge ruled. The claim is based on the fact that **but for the negligent advice, the plaintiff would have had her pregnancy terminated**. Thus the doctor is responsible and caused the child, with her disabilities, to be born. Once proper disclosure of the risks is not made and the woman is deprived of her option, “the damages she has suffered by giving birth to a disabled child are clearly caused by the fault of the doctor, provided she would have terminated the pregnancy if the information had been made available to her”. In upholding the claim for “wrongful birth”, the court relied *inter alia* on the *Edouard* case (*supra*).

The claim for “**wrongful life**” brought by the child **could not succeed**, however, the court held. The judge referred to American precedents and a case decided by the English Court of Appeal in which similar claims had been rejected. The judge concluded as follows:

In my view it would be contrary to public policy for courts to have to hold that it would be better for a party not to have the unquantifiable blessing of life rather than to have such life albeit in a marred way.

Further to allow such a cause of action would open the door to a disabled child being entitled to sue its parents because they may have for a variety of reasons allowed such child to be born knowing of the risks inherent in such decision. Merely to state this proposition is to indicate the unacceptable burden that would be placed on such unfortunate parents.

Finally to allow damages to be claimed on the basis alleged by the plaintiff is completely contrary to the measure of damage allowed for in the law of delict. The defendant was in no way responsible for the child's disabilities and yet he is being asked to compensate the child for such disabilities. This proposition is, in my view, illogical and contrary to our legal system. The only measure of damages can be the difference in value between non-existence and existence in a disabled state. No criteria, in law, can exist in establishing such difference or even in establishing whether any damage has been sustained.

(For criticism of *Friedman's* case, see Pearson FL 1997 SALJ 91 at 105.)

7.2.15.2 "Wrongful birth" and "wrongful pregnancy"

The *Friedman* case concerned liability for the birth of a defective child. As we have mentioned above, the court in this case ruled that there was liability in respect of a claim brought by the mother, on her own behalf, for loss suffered by herself in consequence of the doctor's negligence, that is "wrongful birth" liability.

The next 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. This was the issue in the case of *Chalk v Fassler* 1995 WLD (unreported). This type of case might perhaps also be classified as a "wrongful pregnancy" claim. In this case, Ms C, an unmarried woman, sued Dr F, a gynaecologist, for damages in consequence of the birth of a normal, healthy child. She alleged that Dr F had agreed to perform a legal abortion on her but failed to do so properly or at all. As a result, she alleged, she had remained pregnant and later gave birth to the child. She claimed damages in the form of a loss of earnings while caring for the child and the costs of maintaining the child until it reached majority.

Dr F contended that it had been a term of their agreement that the procedure would not necessarily result in the termination of pregnancy, and that if the pregnancy was not terminated, Ms C had to return to him for further consultation and/or examination with a view to taking further steps to terminate the pregnancy. The doctor denied that he had failed to perform the abortion properly. (The procedure used was dilation and curettage [D & C].) He stated that shortly after the procedure had been performed, Ms C telephoned him and informed him that she had very little bleeding and that she was still nauseous. On the same day, he said, he advised her orally that the possibility existed that she might be pregnant, and requested her to come and see him to enable him to do a uterine scan to ascertain whether she was still pregnant. According to him she chose not to do so and elected to continue

with the pregnancy while it was still medically and legally possible to have it terminated.

On the evidence before it, the court found in favour of Dr F, whom it regarded as a “singularly honest witness”. Levy AJ said that he was satisfied that Ms C had been dishonest in her version of the consultations with two other doctors consulted by her at some stage, and that she falsely denied telling one of them that she had decided to keep her baby and that she needed his assistance to relieve her of the “family pressure” to abort the pregnancy.

Ms C’s failure to inform Dr F “of her continued pregnancy (if that indeed be the case)”, the judge observed, “denied him the opportunity to make any further recommendations or to advise her on any available remedy”. It was her decision not to undergo further treatment at the hands of Dr F. In the event her claim was dismissed.

Another interesting aspect of the judgment should be mentioned.

The question arose whether an undertaking to perform an abortion would *per se* mean that it became a term of the contract between doctor and patient that the abortion would inevitably be successful, and that the doctor would be liable in damages as on a breach of contract if the pregnancy were not thereby terminated. Counsel for Ms C used the analogy of the contract of repair between a motor mechanic and a car owner. The judge observed that “in the light of modern technology motor cars are generally repairable if reasonable care and skill are used”. However, the analogy is false. “There is no room for comparison of treatment of the human body with repairs to a motor car or similar object, and the known risk of failure would be sufficient to deter a surgeon from making such a guarantee”, Levy AJ said.

In any event, he said, the evidence of an expert witness had made it clear that even with the exercise of the requisite degree of care and skill, abortions do occasionally fail. Nor was there “a shred of evidence to suggest that Dr F had in any way been negligent in carrying out the operation”.

On possible indemnity against liability for wrongful birth, we refer you to our remarks at the end of our discussion on sterilisation above.

7.3 Scientific experimentation

At the outset we draw your attention once again to section 12(2)(a) of the Constitution, which enshrines the right of everyone not to be subjected to medical or scientific experiments without their informed consent.

We have already touched on experimentation on the bodies of ailing persons (par 6.2.1 above).

It cannot be doubted that scientific experimentation practised on healthy persons without the direct objective of curing an ailing person or of finding a cure for a particular disease is, within narrow limits, justifiable on the basis of consent. Consent to suffer a minor injury or a temporary slight impairment of health in order to put to the test sound scientific or psychological hypotheses (eg the effect of alcohol on a person) that may be of value to science, may likewise not be viewed as *contra bonos mores*.

Reckless experimentation which is not directed at gaining scientific knowledge, on the other hand, is decidedly illegal, and this also applies to experimentation which may be of scientific value but which entails the likelihood of serious bodily harm or impairment of health.

Where the experiment does in fact take place with the object of curing ailing persons, a consideration in assessing the lawfulness of the operation is the availability of a patient suffering from the disease for which the remedy is sought. Where such a patient is available for experimentation, it will be hard to justify experimentation on a healthy person. If the experiment can be carried out just as well on an animal, it is again clearly unjustifiable to carry it out on a human being.

The risk involved in the experiment must be in relation to the value which a positive result would have for humankind. See the ten principles in regard to human experimentation formulated by the Nuremburg court for the trial of war crimes, quoted by McCoid 12 *Vanderbilt Law Review* (1959) 584–585.

Genetic manipulation of gametes and zygotes (fertilised ova) is prohibited in absolute terms by the Human Tissue Act 65 of 1983 (s 39A).

On experimentation involving children, see Strauss at 420–3. See also our comments below on research on human embryos.

In South Africa the South African Medical Research Council is charged in terms of the South African Medical Research Council Act 58 of 1991 with the duty of exercising proper control over the utilisation of human or animal material in experimentation relating to matters under the control of the Council. A comprehensive set of guidelines was published by the Council in its publication *Guidelines on Ethics for Medical Research* revised ed (1993).

In terms of section 14 of the Medicines and Related Substances Act 101 of 1965 no person may sell any medicine subject to registration in terms of a resolution of the Medicines Control Council, unless it is registered. In terms of section 15 formal application must be made for registration, and the Council may undertake an investigation or inquiry. The Council will evaluate the researcher's protocol for clinical trials prior to its implementation. The application for registration must contain details of clinical studies. The formalities pertaining to applications for clinical trials are set out in GN R510, GG 7636 of 10 April 2003, regulation 34.

As we have mentioned above, section 11 of the National Health Act 61 of 2003 on health services for experimental or research purposes, and section 71 on research on or experimentation with human subjects have not yet been put into operation.

On human experimentation, see also Deutsch E “Medical experimentation: international rules and practice” in Joubert JJ (ed) *Essays in honour of SA Strauss* (1995) 58; Politis A *Aspects of liability for medical research and experimentation in South Africa and England: a comparative study* LLM dissertation University of Pretoria (2003); Van Wyk C “Clinical trials, medical research and cloning in South Africa” 2004 *THRHR* 1. See further our discussion on research on human embryos in parts 7.5 and 7.7 below.

7.4 Artificial insemination

7.4.1 Introduction

Although we treat artificial insemination under the heading of non-therapeutic procedures because it does not necessarily involve the curing of a disease from which the woman is suffering, the reason for this form of insemination is usually that there is some or other problem which prevents normal conception. Thus the husband may be sterile and the spouses so anxious to have a child that they are prepared to let the woman be inseminated with semen obtained from another man. This is known as AID (“artificial insemination, donor”). If there is a conception problem that may be obviated by artificial insemination with the husband’s semen, the procedure is known as AIH (“artificial insemination, husband”). This will be undertaken where there is, for example, some or other abnormality in the woman’s genital tract which prevents the husband’s semen, in the normal process of sexual intercourse, from reaching the ovum. The object with artificial insemination is therefore therapeutic, in a sense, so that we might also have dealt with it under therapeutic procedures.

7.4.2 Statutory regulation

Artificial insemination is a lawful procedure, provided it is performed by a medical practitioner (or a person acting under his supervision, such as a nurse) in accordance with the regulations promulgated by the Minister of Health in terms of the Human Tissue Act 65 of 1983, published in GN R1182, GG 10283 of 20 June 1986 (as amended by GN R1354, GG 18362 of 17 October 1997). Note that the legislature uses the term “artificial fertilisation” in the Human Tissue Act.

It is to be noted that the artificial insemination regulations generally are not applicable to AIH but apply only to AID. (The only regulation applicable to AIH is reg 11, which requires the doctor who performs the procedure to be registered with the Director-General of Health and to work in approved premises.)

Strict control is exercised over donation of gametes. “Gamete” is defined in the Human Tissue Act as either of the two generative cells essential for human reproduction. (The two types of cells are, of course, a spermatozoon in the case of the male, and an ovum (egg) in the case of the female.) No person except a medical practitioner or somebody acting under his supervision may remove or withdraw a gamete from the body of a living person for the purpose of artificial insemination.

A doctor intending to obtain gametes for the purpose of artificial insemination must open a personal donor’s file. Comprehensive written consent must be obtained from the prospective donor.

The donor must consent to the following:

- (1) a physical examination and interview by the doctor
- (2) the taking of samples of gametes for the purpose of testing, analysing or processing

- (3) certain personal details of himself (except his name, date of birth and ID number) being made available to the ultimate recipient
- (4) certain personal details, including his family history, being made available to the doctor who will perform the artificial insemination
- (5) certain confidential details regarding himself being made available to the Director-General of Health.

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

Before undertaking the removal of gametes, the doctor must establish that the donor has undergone, no more than one year earlier, medical tests for sexually transmitted diseases as well as a sperm analysis (in the case of male donors) or a gynaecological examination (in the case of female donors).

In the case of a married donor, the spouse's consent must be obtained in writing. The donor file kept by the doctor who handles the donation must contain an entire range of very specific details provided for in the regulations. *Inter alia* there should be an evaluation of the psychological suitability of the donor for the purposes of artificial insemination.

The donor file must be kept in safe custody. Certain prescribed details must be made available to the recipient and her husband. Each January the doctor must confidentially transmit certain specified particulars to the Director-General. No other person may be furnished with any details on file, except where it is provided otherwise by law or if a court so orders.

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 as a result of artificial insemination involving the same donor, and that the possibility exists of two more simultaneous pregnancies as a result of that procedure, 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 in which a series of details prescribed in the regulations must be recorded. These include details of medical examinations and tests, and written consent.

An artificial insemination may be performed on an unmarried woman as well as a 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 by virtue of the Children's Status Act 82 of 1987 (see below).

Before artificial insemination can take place, the doctor must ensure that the recipient and (if she is married) her husband are informed by appropriate experts of the possibilities of natural conception as well as of all the implications of artificial insemination, including potential problems with the technique, the chances of success, the financial aspects, the consequences for

the marriage (in the case of married persons), the ethical, psychosocial and educational implications, etcetera, and legal advice.

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

Where the recipient or the donor comes from a population group in which the individual runs a high risk of being a carrier of a specific genetic defect, for example Tay-Sachs disease or thalassemia, they must be properly tested.

Likewise, where, on account of the family history, the possibility exists that the recipient or donor is the carrier of a defect which can be transmitted by genes or chromosomes, examinations and tests must be carried out. If the tests are positive, genetic counselling must be given to the recipient couple, and the donor's semen may not be used.

A proper recipient file must be kept containing the prescribed information, and certain details must be transmitted to the Director-General in January of each year. Proper confidentiality must be maintained at all times.

Doctors who intend undertaking artificial insemination must apply to the Director-General for special registration. Doctors so registered may perform the procedures only in premises approved by the Director-General and subject to special or general conditions imposed by him.

A doctor who has effected 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 back to the donor or the recipient. If the effect can be traced back to the donor, the doctor who handled the donation must be notified.

It is a criminal offence for a doctor to act other than in accordance with the regulations.

7.4.3 The legal position of the AID child

Prior to 1987 a child conceived by means of AID was regarded as illegitimate. See *V v R* 1979 (3) SA 1006 (T). In 1983 the Human Tissue Act was enacted, and this Act, together with the artificial insemination regulations promulgated thereunder in 1986, created *in extenso* regulation of AID practised within a marriage, thereby giving the legislature's blessing to the procedure as such. But a question mark continued to hang over the legal status of children thus conceived, in consequence of the 1979 Supreme Court ruling.

In 1987 the legislature finally removed all doubt by enacting the Children's Status Act 82 of that year. In terms of section 5 of the Act, a child born to a woman in consequence of AID, practised with the consent of her husband, is deemed for all purposes to be the legitimate child of the woman and her husband. The section further provides that it is legally presumed, until the contrary is proved, that both spouses have given consent.

As we have seen above, the artificial insemination regulations require consent to AID to be in writing. It has, therefore, become of the utmost importance

for medical practitioners to comply strictly with that requirement in order to obviate a subsequent dispute of the kind that arose in *V v R*. If the consent requirement is disregarded, the unfortunate result will be that the child will be regarded as illegitimate.

The Children's Status Act 82 of 1987 defines artificial insemination in such terms that it includes *in vitro* fertilisation (IVF). It further provides that no right, duty or obligation shall arise between a child born as a result of the gamete or gametes and his/her blood relations, unless,

- (1) the donor is the woman herself who gave birth to the child, and
- (2) the donor is the husband of the woman at the time of the artificial insemination

The Act has also brought complete legal certainty in this respect.

Because artificial insemination of unmarried women was declared legal in 1997, the child born to the woman will be regarded as illegitimate. The Children's Status Act 82 of 1987 only governs children born to married women.

7.4.4 The potential liability of the doctor

As far as the liability of the doctor is concerned some factors of a more academic nature come into play. If the medical practitioner who performs the artificial insemination acts with the consent of both spouses, there is little danger of delictual or criminal liability, whether the donor of the semen is the spouse or another man. In our opinion, if the medical practitioner acts without the consent of the woman, his conduct amounts to a serious *iniuria* against the woman, which may incur both civil and criminal liability. If the medical practitioner acts without the consent of the husband, his conduct may likewise constitute *iniuria* against the latter.

Performing artificial insemination on an unmarried girl under the age of sixteen years — if such foolishness is conceivable — can possibly make the physician liable in terms of the Sexual Offences Act 23 of 1957. The question which must be decided here is whether the artificial insemination constitutes the commission of an “immoral or improper act” with the girl (which, in terms of s 14, Act 23 of 1957, constitutes an offence).

There is a distinct possibility that if a semen donor is HIV-positive, the woman who is artificially fertilised and/or her child may be infected. (An American case was reported in 1990 of the wife of a haemophiliac who became infected with the AIDS virus after undergoing artificial insemination in an effort to conceive a child. Her husband's semen had been used [*The Citizen*, 21/4/90].) Depending on the circumstances and the proof of negligence, the donor and/or the agency supplying the semen may be held liable for damages. Only in extremely exceptional circumstances would the doctor who performed the insemination incur liability.

If a doctor is negligent in using semen, for example by obtaining it from a donor with a venereal disease or who is too closely related to the recipient, so that a defective child is born, there is a possibility of liability on the basis of wrongful birth.

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 fulfil his undertaking, there may be liability arising from breach of contract. But proof of damage or loss may be an insurmountable obstacle for the couple.

7.5 Embryo transfer, *in vitro* fertilisation (IVF) and surrogate motherhood

7.5.1 Embryo transfer

A procedure which was first successfully applied to animals, is the transfer of a fertilised ovum from “mother” A to “hostess” B. In this manner a far greater number of A’s children may be born than A would have been capable of bearing herself. A champion cow, for instance, will ordinarily every three weeks produce an ovum which may be fertilised. However, the period between the conception and birth of the offspring is approximately nine months.

Now science has developed a method whereby the cow’s ovum may be fertilised within the cow itself and shortly afterwards may be removed and implanted into the uterus of the “hostess” cow. By means of hormonal stimulation the cow may even be induced to hyper-ovulate and may produce up to 20 ova per ovulation. All these ova are then simultaneously fertilised in the normal manner and are shortly afterwards removed from the cow and individually implanted into other cows’ uteri. (Hyper-ovulation may be induced twice in a 12-month period, which means that up to 40 calves may be had from the same cow and bull every 18 months!)

In July 1983 it was reported in the press that 1 000 embryos of dairy cows had been flown from Britain to Egypt in a container the size of a suitcase. If the calves themselves had to be flown, so the report said, it would have cost R340 000!

This procedure holds all kinds of potentialities for mankind, some of which are revolting. The possibility exists that a megalomaniacal ruler could order a race of “supermen” to be bred. To achieve this, a series of selected “super women” could be used to produce ova which would then be fertilised with the semen of a single “super male”. The fertilised ova could then be transferred to “hostesses” in whose uteri the embryos would grow and ultimately be born as “normal” children. Without doubt such a scheme would grossly offend against the current *boni mores*, and must therefore be considered unlawful.

7.5.2 *In vitro* fertilisation (IVF)

However, a comparable procedure — which does not amount to an actual transfer — may be employed to aid a woman who is afflicted with the problem of being unable to conceive. This was in fact done for the first time with the so-called “test tube” baby who was conceived in England and born in 1978 (as a result of the work of Drs Steptoe and Edwards). The woman, Mrs Lesley Brown, could not fall pregnant on account of an abnormal condition of her Fallopian tubes (the tubes through which the egg in the normal course

descends into the uterus). By means of a needle a ripe ovum was removed from the ovary. It was placed in a laboratory dish (the medical term is *in vitro*, ie “in glass”) and sperm from her husband was added to it. The egg was fertilised and after a few days the developing embryo was placed into the woman’s uterus. There it attached to the wall of the uterus and developed in the normal manner until the child was born.

In 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 65 of 1983 (s 23). In fact, the procedure is altogether therapeutic.

By virtue of the 1984 amendment to the Human Tissue Act, artificial insemination is defined in such wide terms that it includes *in vitro* fertilisation. Artificial insemination is defined as the introduction by other than natural means of a male gamete or gametes into the internal reproductive organs of a female person for the purpose of human reproduction, including

- (a) the bringing together outside the human body of a male and a female gamete or gametes with a view to placing the product of a union of such gametes in the womb of a female person; or
- (b) the placing of the product of a union of a male and a female gamete or gametes which have been brought together outside the human body, in the womb of a female person for such purpose

This definition is wide enough to embrace *in vitro* fertilisation with a view to the introduction of a fertilised ovum into the womb of a “hostess” or surrogate mother. The regulations regarding artificial insemination (see above) apply to *in vitro* fertilisation as well. The regulations define *in vitro* insemination as “the bringing together outside the human body of a male and a female gamete and the placing of the zygote in the womb of a female person”. A zygote is defined as “the product of the union of a male and a female gamete outside the human body”.

7.5.3 Surrogacy agreements and legal status of the child

Surrogacy entails a commissioning couple entering into an agreement with a woman in terms of which the latter will bear a child for them. The Human Tissue Act does not govern the juristic relationships between the genetic parents of the child and the surrogate mother. There are several unsolved legal problems in this connection. An agreement between the woman whose ovum has been fertilised and the hostess, in terms of which the hostess undertakes to give the child after its birth to the former, will probably be regarded by our courts as unenforceable, and the same applies to an undertaking to compensate the hostess for her “services”. According to prevailing juristic convictions such an agreement would seem to be *contra bonos mores* and therefore illegal.

A few cases concerning surrogate motherhood have come before the courts in America and England. In England the Surrogacy Arrangement Act 1985 has made the conducting of commercial surrogacy a punishable offence, but only where third parties are involved. Criminal sanctions are imposed on

commercial brokers who make, negotiate or facilitate a surrogacy agreement for payment. The Act does not, however, apply to the commissioning couple and a surrogate mother who conclude a surrogacy agreement, and it would seem, according to Tager L “Surrogate motherhood, legal dilemma” 1986 *SALJ* 381 that no prohibition is placed on the payment of a fee to the surrogate mother. See also Pretorius R “Surrogaat-moederskap: implikasies in die Suid-Afrikaanse regstelsel” 1987 *DR* 270.

In South Africa the Children’s Status Act 82 of 1987, to which we have made reference above, was clearly not intended to regulate surrogate motherhood as such in any detail. It is nevertheless clear from the wording of section 5 that cases of surrogate motherhood will also fall within the ambit of its provisions. A child born to a surrogate mother who is married, is therefore now legally deemed to be the child of herself and her husband, and not that of the genetic parents. Married couples who consider the possibility of surrogacy, and their doctors, must take these provisions fully into account. The commissioning couple will have to apply for adoption of the child in terms of the Child Care Act 74 of 1983. Alternatively the couple could apply to the High Court for an order whereby the guardianship of the children would be awarded to them. The High Court is the upper guardian of children, and may make an order which in its judgment would be in the best interests of the child.

As we have mentioned above, a child born as a result of artificial insemination to an unmarried woman will be regarded as illegitimate. The commissioning couple may then follow the procedure required for adoption of an illegitimate child.

It is clear that, sooner or later, the legislature will have to attend to the legal issues involved in surrogate motherhood. The South African Law Commission launched an investigation into surrogate motherhood, and in its report (1991) recommended that legislation be passed to establish its lawfulness, subject to certain stringent conditions. A draft bill was also published.

The consensus of legal opinion in South Africa seems to be that surrogacy agreements are not *per se* unlawful. (See Tager L 1986 *SALJ* 381; Pretorius R 1987 *DR* 270. For a full discussion of the possible contents of a surrogacy contract, see Pretorius R “A comparative overview and analysis of a proposed surrogate motherhood agreement model” 1987 *CILSA* 275–293.) If, however, the arrangement assumes a commercial or profitable character in the sense that a substantial financial consideration is paid to the surrogate mother, the agreement will be unenforceable as being *contra bonos mores*. It is further accepted that, quite apart from the latter aspect, a surrogacy agreement would be unenforceable in absolute terms by the genetic parents against the surrogate mother. Should a legal dispute arise, the High Court will clearly be guided by considerations of what would be in the best interests of the child. (On surrogacy motherhood in general, see Pretorius D *Surrogate motherhood: a worldwide view of the issues* (1994).)

In 1987 history was made in regard to surrogacy motherhood when a married grandmother, Mrs Anthony, from Tzaneen, on 1 October of that year gave birth in Johannesburg to triplets, the genetic parents of which were Mrs Ferreira-Jorges (Mrs Anthony’s own daughter) and her (Mrs Ferreira-Jorges’) husband. As far as is known, this was the first case of its kind in the world.

Even before the birth of the Tzaneen triplets the question arose concerning who would be regarded as the legal parents of the children. The first practical issue was the following: In whose names were the children to be registered? The eventual settlement of this issue was not without a touch of drama in view of the fact that as the expected delivery date of the triplets approached, the Children's Status Bill with the provisions outlined above had already passed through Parliament, but had not yet been signed by the State President and published in the Government Gazette.

As it happened, the birth of the babies preceded the promulgation of the Children's Status Act by a mere thirteen days. But the sequence was of the utmost importance, and the Registrar of Births, Marriages and Deaths decided that the triplets had to be registered, not as the children of their grandmother who had actually given birth to them, and of her husband, but as those of their genetic parents: the ideal state of affairs for all involved. Had the babies been born thirteen days later, the inevitable outcome would have been that they would have been registered as the children of their genetic grandparents: *ergo*, their genetic grandmother and birth mother would legally have been one and the same person!

7.5.4 Experimentation on embryos

This discussion on experimentation on embryos will be affected when chapter 8 of the National Health Act 61 of 2003 eventually takes effect.

Reports in the press in 1982 that Dr Edwards (see 7.5.2 above) had experimented on human embryos fertilised *in vitro*, resulted in a torrent of criticism, but it was subsequently stated by the British Medical Association that he had not made himself guilty of any unethical conduct.

During 2001 the subject of stem-cell research on human embryos unleashed a vehement debate internationally. Stem cells are the basic cells that form all the cells in the body. Some call them "magic seeds" because of 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 that stem cells could be used to cure diseases once regarded as untreatable, such as Parkinson's disease, Alzheimer's and diabetes. (Adult stem cells may also be used for research. They are "harvested" from bone marrow and brain tissue. It is not yet clear, however, whether adult stem cells will prove as versatile as embryonic ones.)

The fact of the matter is that a large number of unused and "unwanted" embryos are presently stored in freezers of fertility clinics. During *in vitro* fertilisation clinics routinely fuse more than one egg with sperm. Many of these are not used. Many foetuses are also discarded in abortion clinics. Some researchers have created embryos purely for research purposes or as sources of stem cells. Some scientists have even tried to create cloned human embryos for this purpose. Some of these activities are highly controversial. There are millions of people all over the world who regard fertilisation as the commencement of human life, and the destruction of an embryo or foetus is contrary to their religious beliefs. On the other hand many scientists argue that it is a fact that thousands of embryos and foetuses would in any event be

thrown away, and that it would be far better to use these for purposes of research which may eventually result in medical breakthroughs that can benefit a countless number of ailing persons.

In terms of the Human Tissue Act 65 of 1983 the Minister of Health is vested *inter alia* with the power of making regulations relating to research with regard to the product of the union of male and female gametes outside the human body (s 37(1)(e)(vii)). No such regulations have been made to date. As we have pointed out above, however, genetic manipulation of gametes or zygotes outside the human body is absolutely prohibited by the Human Tissue Act (s 39A). (A zygote is the cell resulting from the fusion of two gametes, ie the fertilised ovum.) To the extent that stem-cell research would involve genetic manipulation, it would accordingly be illegal in South Africa.

The South African Medical Research Council (MRC) has laid down basic ethical guidelines on research relating to reproductive biology (see its *Guidelines on ethics for medical research: Book 2: reproductive biology and genetic research* (2002)) such as the following:

- The pre-embryo should be treated with the utmost respect because it is a genetically unique, viable human entity.
- If pre-embryo transfer to the uterus is envisaged, special care should be taken to ensure the welfare of the potential foetus.
- The production of excess embryos for the sole purpose of research should be discouraged (par 2.2). (A pre-embryo is defined as the product of gamete union from the time of fertilisation to the appearance of the embryonic axis. The pre-embryonic stage is considered to last for 14 days.)

As far as IVF is concerned, the MRC states that there is consensus that there is no intrinsic moral problem in respect of the use of this technique in cases where gametes from the husband and wife are used (par 2.3). Research to improve the efficacy of gamete intrafallopian transfer (GIFT) is ethically acceptable (par 2.4).

The MRC recommends that research methods into artificial insemination-donor (AID) should be limited to the essential, and that adequate consent should be obtained from all people involved in the donation or reception of gametes. Artificial insemination procedures should be performed in full compliance with the regulations promulgated in terms of the Human Tissue Act (par 2.6). Proper counselling and consent are required where donor sperm is used (par 2.7). The use of donor eggs remains controversial, but provided the donor receives no compensation, the MRC finds the use of donor eggs ethically acceptable. However, attempts to extend child-bearing beyond the menopause have many medical, familial and sociological disadvantages, and research in this field is usually ethically unacceptable (par 2.8).

As far as embryo transfer is concerned, the MRC is of the opinion that the transfer of more than four embryos may occasionally lead to multiple pregnancies of a grand order, and is therefore not recommended (par 2.9). Uterine lavage for pre-embryo transfer carries the risk that some of the pre-embryos may be retained in the uterus (par 2.10). Maintenance of embryos *in vitro* beyond the gestational age of two weeks is not ethically acceptable (par 2.14).

Research into the selection of foetal sex may be inappropriate if it could result in a request for an abortion because the sex of the foetus is unacceptable to the parents. On the other hand gender selection may be beneficial in sex-linked genetic diseases, and may be justified under exceptional circumstances (par 2.16).

Pre-embryo manipulation and research may yield valuable medical information. It can, however, only be regarded as ethical if the embryos are not produced specifically for the purpose of research. In addition, the embryos should not be transferred to the uterus unless there is reasonable certainty that the manipulation carries no potential risks for the foetus (par 2.17).

The use of recombinant technology in selecting foetal sex is currently regarded as not ethical (par 2.18).

In regard to stem-cell and embryo research, see also our discussion below in part 7.7.

7.6 “Sex-change” (Transsexualism or Intersexuality)

The legality of such operations — many of which have already been performed, also in South Africa — is speculative. If such a case ever came before a South African court, the court in our opinion ought to be led by the question whether consent to such an operation conflicts with the *boni mores*.

This operation concerns the fate of the so-called “transsexual” — a person who has a normal male physique but feels emotionally like a woman or who, *vice versa*, is physiologically a woman but feels emotionally like a man. Medical practitioners emphasise that the transsexual is different from the hermaphrodite — a person born with the sexual organs of both sexes — and from the ordinary homosexual who merely has a sexual orientation towards his or her own sex. According to doctors and psychologists, the transsexual is usually a deeply unhappy person whose condition gives rise to serious personal psychological problems. Apparently psychiatric treatment is of little assistance in surmounting these problems. Through surgery, however, the transsexual can be given at least the appearance of the sex with which he or she identifies him- or herself.

This type of operation is popularly known as a “sex-change operation”, but certain doctors are of the opinion that the term is misleading because the sex of a person is determined at conception and is dictated by chromosomes. (A chromosome is a small body which appears in the nucleus of a cell at the time of cell division. Chromosomes contain the genes, or hereditary factors, and are constant in number. The normal number in man is 46, with 22 pairs of autosomes and 2 sex chromosomes. Male and female chromosomes can as a rule be clearly distinguished.) Therefore it is contended that a change of sex is physically impossible.

Other medical experts are, however, of the opinion that sex is primarily a question of psychological orientation and not so much of physiological appearance. They apply a psychological criterion in order to determine sex. Whatever the case may be, it is apparently quite impossible to reverse the roles in respect of the procreative function through such operations, although

the operation does enable the patient to adjust himself physiologically to the other sex, which might resolve certain psychological problems.

In our opinion consent to “sex-change” by an unmarried person with a view to 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. And yet, in our opinion, it is not inconceivable that if such a case were to come before court, it might appear that actual psychotherapeutic considerations could also be decisive in the interests of children or potential children. In the absence of such exceptional circumstances, it might be argued that consent to an operation on a married person could be judged as conflicting with the *boni mores*. But that argument will without doubt be met with the counter-argument that each person has the right to self-determination (personal autonomy).

There have been several cases in South Africa and elsewhere in the world concerning the effect of the “sex-change” operation.

In the Argentine in the case of *Dr Ricardo San Martin* (1966) it was held that a surgeon who performed a sex-change operation on an unmarried male homosexual was guilty of grievous assault. The accused argued that he had acted on strictly therapeutic grounds, namely the removal of cancer from the penis, but the court rejected this defence. The court found that the operation conflicted with “the social norm — the law above all the norms of (positive) law and morality — that of the preservation of the species”. The court found further that consent was no defence, because on the one hand the patient’s mental age was 12 years and on the other the consent was obtained by “corruption”. (The case is discussed in detail by Strauss 230 *et seq.*)

In the Belgian case of *Dr Fardeau et alii* (1969) the accused were charged in consequence of the death of a transsexual who had died as a result of a series of pulmonary emboli following conversive surgery. The prosecution contended *inter alia* that the accused could not rely on the defence of justification since they had not acted with a curative objective. The accused, on the other hand, claimed that the surgery had been undertaken with the objective of restoring the patient’s psychological equilibrium and of facilitating his social reacceptance. Upholding the defence contention, the court confirmed the view that the knowledge which a judge possesses does not entitle him to interfere with conflicting views held by medical experts regarding the nature of transsexualism and the efficacy of surgery as a cure. (The case is discussed by Strauss 231.)

In another Argentinian case, that of *Dr Francisco Defazio* (1969), the court upon appeal quashed three convictions of aggravated assault following sex-change operations. The first operation involved a patient who had been diagnosed as a pseudo-hermaphrodite. An examination had brought to light that there was total atrophy (wasting away through imperfect nourishment) of one testicle and partial atrophy of the other. Medical experts claimed that the patient was physically a male, although there was evidence of some female characteristics. The appeal court held that the operations performed by the appellant were not injurious to the patient. No useful organs were removed, and both operations were intended to adapt the patient to his true

psychological sex. The other two charges involved true transsexuals, namely patients who had had normal external male genitals, but whose behaviour had been that of a woman. The appeal court held that even if it were to assume that the operations on these two patients were injurious to their bodies and health, there was no proof of *dolus*. It was held that a physician is under a duty to proceed according to what he considers best for his patient, and that a judge should be extremely cautious in passing judgment on this. (See Strauss 232.) This case clearly indicates a departure by the Argentinian court from the views expressed in the earlier *San Martin* case (*supra*).

In the English case of *Corbett v Corbett (otherwise Ashley)* [1970] 2 All ER 33, the court based its decision entirely on biological criteria. In this case the applicant, a man who married a transsexual who had undergone conversive surgery, obtained an order declaring the marriage null and void. It was common ground between all the medical witnesses that the biological sexual constitution of an individual was fixed at birth (at the latest) and could not be changed, either by the natural development of organs of the opposite sex, or by medical or surgical means. The court held that these (biological) criteria, and not the psychological factor, were decisive. Since marriage was essentially a heterosexual relationship, the parties' "marriage" was a nullity. (This decision has been criticised on the ground that the psychological factor was underrated and that the court's view "vetoed the attitudes dictated by ordinary humanity". See Van Niekerk vD "Sex change operations and the law" 1970 SALJ 239.)

In *R v Tan* [1982] 2 All ER 12 (CA) the English Appellate Division applied the decision in the *Corbett* case in ruling that a "converted" female transsexual (ie from male to female) nevertheless qualifies as a male for the purposes of a provision in the Sexual Offences Act 1956, which renders it a criminal offence for "a man knowingly to live wholly or in part on the earnings of prostitution". (See the note on the case by Taitz J "Some criminal law anomalies brought about by a sex change" 1985 THRHR 97.)

In the USA a court refused to consider a refusal by an official Bureau of Statistics to change the registration of a person's sex from "male" to "female" after the applicant had undergone a sex-change operation. See *Anonymous v Weiner* 270 NYS 2d 319 (1966). But in *MT v JT* 355 A2d 204 (NJ 1976) an American court upheld a marriage between two biological males, and required the "husband" to pay spousal support to the "wife" since the male spouse had become physically, psychologically and anatomically female. The court held that where a transsexual was born with the physical characteristics of a male, but successful reassignment surgery harmonised her gender and genitalia so that she became fully capable of sexual activity as a woman, such a transsexual became a member of the female sex for marital purposes. Her subsequent marriage to a male, accordingly, was not void.

In South Africa, following a decision in which a divorce order was granted to a "married" female transsexual (*Jonker v Jonker* 1970 (T), unreported, discussed by Strauss 236), section 7B was inserted in 1974 in the Births, Marriages and Deaths Registration Act 81 of 1963 allowing "converted" transsexuals to re-register as the opposite sex. Subsequently, in *W v W* 1976 (2) SA 308 (W), the court considered the marital status of a married

transsexual, and ruled that the typical “sex change” operation did not result in a biological change of sex, and that a “marriage” entered into between the parties was null and void. In 1992 section 7B was removed from the statute book.

Since then there has been a marked change in societal attitude towards “sex change”, which is echoed in the Alteration of Sex Description and Sex Status Act 49 of 2003. This Act provides for a change of sex description in the birth register in the case of a person whose sexual characteristics have been altered by surgical or medical treatment or by evolvement through natural development resulting in gender reassignment (s 2(1)). According to section 1, “gender reassignment” means a process which is undertaken for the purpose of reassigning a person’s sex by changing physiological or other sexual characteristics, and includes any part of such a process. “Sexual characteristics” means primary sexual characteristics (the form of the genitalia at birth), or secondary sexual characteristics (the characteristics which develop throughout life and which are dependent upon the hormonal base of the individual person, or gender characteristics (s 1)). “Gender characteristics” is defined as “the ways in which a person expresses his or her social identity as a member of a particular sex by using style of dressing, the wearing of prostheses or other means” (s 1). This Act clearly acknowledges the concept of “sex change” and upholds the psychological criterion as the decisive factor.

Finally we want to point out that an operation performed on a person who possesses the sex organs of both sexes (the hermaphrodite) so as to enable the person to be more compatible with one sex is, in our opinion, lawful if the required consent is present. Hermaphrodites will most probably fall within the definition of an “intersexed” person, who, in terms of section 1 of Act 49 of 2003, is a person whose congenital sexual differentiation is atypical, to whatever degree. This means that a hermaphrodite may also apply for the alteration of the sex description on his or her birth register.

The Constitutional Court judgment in *Minister of Home Affairs v Fourie (Doctors for Life and Others, Amici Curiae); Lesbian and Gay Equality Project and Others v Minister of Home Affairs* 2006 (1) SA 524 (CC), in which the constitutionality of same-sex union was upheld, has greatly diminished the importance of the legal recognition of the change of sex effected by a sex change operation in so far as it might have a bearing on the validity of a marriage.

Since the 1980s serious doubts have arisen in medical circles regarding the ultimate success of “sex-change” operations, and some doctors and medical centres have discontinued their work in this field. See Kahn E “The true hermaphrodite — of no sex?” 1981 *SALJ* 111. However, surgery which is undertaken to assist the true hermaphrodite is still regarded as fully justifiable from the medical as well as from the societal point of view (*ibid*, and see also Strauss 238). It should also be mentioned that “sex-change” operations are still being performed here and there.

7.7 Genetic engineering

7.7.1 Introduction

Up to now we have occasionally mentioned aspects of what can broadly be described as human genetic manipulation, for example artificial insemination, and experimentation on embryos.

Genetics is the study of heredity. The term “genetics” comes from the word “gene” which is the biologic unit of heredity located on a particular chromosome. The chromosomes are small, more or less rod shaped bodies which appear in the nucleus of a cell at the time of cell division. They contain the genes or hereditary factors. The genes determine the thousands of characteristics which living things inherit from their parents — such as hair colour, eye colour and height, to mention only a few. Genetic information is stored in living cells in long chainlike molecules of deoxyribonucleic acid (DNA). DNA forms chromosomes that are part of cells of all living organisms. These DNA chains carry hereditary “coded” instructions that cells follow to make proteins, the prime molecules of life. DNA accordingly carries the hereditary information that an organism passes on to its offspring — it determines that a cat will produce a cat, not a dog.

For many years now it has been possible for doctors to pick up genetic information such as a genetic disorder in a foetus *in utero* by means of amniocentesis — examining the fluid in the uterus surrounding the foetus. In cases where a serious disorder is detected, the doctor may advise the parents to have the pregnancy terminated.

Advances in biology in the latter half of the twentieth century have enabled genetic engineers to develop and refine a number of micro-techniques to “cut”, “excise”, “insert” or “recombine” certain sequences of DNA, which means that they are now able to manipulate heredity material, and therefore heredity itself, in ways never dreamt of before. With techniques of cloning, for example, it is now possible to make identical copies, not only of cells, but also of individuals. We shall return to this below. It is also possible to introduce new characteristics to the functioning of existing cells or organisms.

Once scientists know how each human gene works and how it can malfunction, they can design sensitive diagnostic tests, find the genetic roots of diseases, customise medicines to each individual’s unique genetic make-up — and perhaps even replace defective genes with normal ones.

Research into gene therapy began late in the twentieth century. Gene therapy involves a process whereby corrective implants are used to treat a wide range of diseases, from hereditary illness to cancer and heart disease. So far human trials have been somewhat disappointing. But it is now possible to combat haemophilia B by cutting patients’ dependence on injections of blood clotting factors. Early in 2000 a breakthrough was also reported in combating a genetic disorder in the form of severe combined immunodeficiency X1 in babies. Babies were given a normal copy of the defective gene responsible for the disease. Bone marrow transplantation, which is a risky procedure, is thus avoided.

Another development is of benefit to infertile women. The genetic make-up

of such a woman can be introduced into an ovum (egg) donated by a fertile woman, so that the resulting child will carry the infertile woman's genes instead of the donor's.

“Tampering” with genes, the very blueprint of life, of course not only affects human beings; it also opens a vast field of application in farming and agriculture. For example, at the beginning of 2000 it was reported that scientists had by genetic engineering induced goats to produce strands of a very powerful silky web spun by a certain type of spider in their milk, and this “silk” was said to be suitable for industrial use. However, besides the benefits that may be reaped from improved crops or the eradication of devastating genetic diseases in animals and humans, there is also the downside, namely that recombinant DNA technology empowers man with the means of creating new forms of life that may threaten our biological survival on this earth and our spiritual health, our freedom and sense of personal autonomy.

Please note that for the purposes of this course we are mainly interested in the ethical acceptability and legality of forms of genetic engineering.

7.7.2 Gene therapy

It goes without saying that curing patients with serious ailments by means of gene therapy, as described above, is deserving of praise and altogether lawful. The same is not true of unlawful experimentation with persons or human embryos.

Although gene therapy is practised today in a number of countries, it has not yet been assimilated into mainstream medical practice. It is still perceived to be different, both in its nature and possible consequences, from any treatment used hitherto in medical practice. According to the South African Medical Research Council (MRC) gene therapy should be considered to be in the research stages and therefore subject to those ethical considerations that currently govern genetic and medical research.

For a detailed discussion of these ethical considerations, consult the MRC publication *Guidelines on ethics for medical research* Book 2 (2002) 6–15.

7.7.3 Genetic counselling

Genetic testing and counselling of individual patients with genetic disorders or the potential parents of a baby with a severe genetic disorder, is already widely practised all over the world and accepted as beneficial. Genetic screening programmes performed in society at large can also play an important role in public health care. They can be costly, however, and may raise serious ethical issues if applied only to select groups or parts of a population. The factor of confidentiality of screening results also comes to the fore.

For a comprehensive discussion of the ethics involved in both individual genetic testing and genetic screening in general, see the MRC Book 2 (2002) 15–37.

7.7.4 Human Genome Project

At this point reference should be made to the international Human Genome Project.

The term “genome” refers to the complete set of hereditary factors of a person as contained in his or her chromosomes. The haploid human genome (genetic information contained in one gamete) consists of approximately three billion basepair sequences. An international effort to sequence the whole of the human genome, the so-called Human Genome Project, was officially launched in October 1990. It was originally expected that the project would last 15 years, but rapid technological advances accelerated the completion date to 2003. Rapid advances in the automation of laboratory and computer technologies made this gigantic project possible.

Predictions are that early in the 21st century it may become possible to obtain the total genetic information of an individual on a computer (compact) disc. A few simple questions arise: Do you want to know your genetic makeup? Will it be acceptable that your employer, your spouse or an insurance company knows your genome?

The primary aim of the Human Genome Project is to advance knowledge rather than to identify disease mutations. Its most important outcome will be to increase understanding of the ways in which genes interact with each other and with the environment to generate normal structure and functions. Part of the work of the international Human Genome Organisation (HUGO), known as the Human Genome Diversity Project, is aimed at increasing understanding of human evolution. The latter project is rather controversial. In a world in which so-called “ethnic cleansing” is a tragic reality, it has been suggested that the findings of the project may even serve as an inducement by nations or groups to go to war against other nations or groups.

The compilation of a complete genetic map of each individual raises many ethical and legal issues. To mention only two more in addition to those alluded to above: Who owns DNA sequence data? Who should be screened for what and by whom?

Difficult questions have already been raised in regard to the patentability of human genes or genetic information gained in the process of genome mapping and “decoding”.

Genome mapping is a huge undertaking. It entails the spelling out in correct order of the molecular “letters” that make up the genetic code embedded in our DNA. The overall genome has some 3,4 billion letters. (It has been said that this can be compared to the number of letters contained in 800 Bibles.) (On the Human Genome Project, see Murphy TF “Mapping the human genome” in Kuhse K & Singer P (eds) *A companion to bioethics* (2004) 198.)

7.7.5 DNA typing (“fingerprinting”)

Some mention should also be made here of the so-called DNA “fingerprinting”. The technology for this was introduced in 1985 by a scientist, Jeffreys, to obtain a positive identification in an immigration case in the United Kingdom. This technique has many possible implications for both criminal prosecutions as well as civil litigation (eg the proof of paternity). DNA

analysis can now be made from very small samples of human blood or tissue (hair, bone, flesh) including body fluid such as semen and saliva. It is known that the skeletal remains exhumed in a Siberian forest in the early 1990s were positively identified as those of Tsar Nicholas and members of his family who were murdered by Soviet militants in 1918. DNA typing with tissue samples obtained from living relatives of the Tsar was done by scientists.

DNA fingerprinting has raised a number of ethical and legal issues such as: Is the consent of a suspect or victim required for DNA analysis? How long may the DNA findings and samples be stored or preserved? May law-enforcement agencies prepare “catalogues” of findings? Can insurers and employers get access to such catalogues? As yet we do not have answers to all these questions. The living individual’s right to privacy is, of course, constitutionally enshrined in principle. But what about data pertaining to deceased persons that may be of considerable importance to the interest of living relatives?

In *Ex parte Emmerson* 1992 (3) SA 987 (W) a man was killed in a motor-vehicle accident. Later that day, Ms E, who was seven-and-a-half months pregnant and claimed that the deceased was the father of her unborn child, applied to court for an order authorising the performance by the SA Institute of Medical Research of DNA “fingerprinting” of tissue obtained from the deceased’s body in order to establish paternity. The court granted the order.

Section 225 of our Criminal Procedure Act 51 of 1977, read with section 37, authorises the taking of fingerprints and other steps by a police official to ascertain whether the body of a criminal suspect has, *inter alia*, any “characteristic or distinguishing feature”. In *S v Huma and Another* (2) 1995 (2) SACR 411 (W) Claassen J held that the taking of fingerprints against the will of the accused is not unconstitutional. We are of the opinion that these statutory provisions may also be relied upon to authorise, for example, DNA analysis for identification purposes in criminal cases. That was in fact also the decision in the case of *S v Orrie and Another* 2004 (3) SA 584 (C).

In *S v R and Others* 2000 (1) SACR 33 (W) the court observed that DNA testing goes a long way towards liberating men from unfounded charges of rape and women from humiliating questions with regard to allegations of rape. In this case the accused had been told that “their blood would be tested with that of the complainants”, and they consented. The court ruled that this constituted an adequate consent to the taking of a blood specimen for DNA testing. There was no violation of their constitutional rights.

7.7.6 Cloning

The term “clone” is derived from the Greek word “klon” which means twig. “Clone” refers to a group of identical individuals, particularly plants, which originate by natural or artificial means through asexual procreation from a single individual, so that the members of the group — apart from modification or eventual modification — are identical in all respects.

Cloning — the artificial “photocopying” as it were — of a mammal was first achieved in 1997 with Dolly the sheep by Scottish embryologists in Edinburgh. Early 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. Nuclear transfer requires the nucleus of a cell from an individual to be inserted into an unfertilised egg (ovum) 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. The possible applications are threefold:

- (1) reproduction, that is to produce a baby by transferring the cloned embryo into the womb of a mother
- (2) the treatment of metabolic diseases caused by problems in the mitochondria of cells — “power packs” which produce energy
- (3) the production of tissue to be used for the treatment of degenerative diseases of the heart, liver, kidneys and cerebral tissue, or to repair damage to skin or bone

Some scientists have claimed that stem cells obtained from cloned embryos can even be used to grow complete human organs, but others maintain that this is impossible to achieve in laboratories because organs develop only within the body. Early in 2000 it was reported that a Japanese scientist had grown frog eyes by means of genetic engineering.

In December 2001 an American biotech firm announced that it had actually cloned the first human embryo. The announcement evoked mainly revulsion. An Italian gynaecologist, Dr Antinori, however, announced that he was very close to cloning a human baby. At the end of 2002 and during the first days of 2003 claims were made that human babies were born following successful cloning, but these claims were unconfirmed and scientists remained sceptical. The claims did, however, trigger a world-wide revulsion.

As yet there is no express legislation in South Africa regulating or prohibiting cloning of human beings. Reproductive cloning of human beings will be prohibited by section 57 of chapter 8 of the National Health Act 61 of 2003 once it takes effect, though. However, therapeutic cloning as well as stem-cell research may become conditionally lawful.

Reference must be made here again, however, to the prohibition of genetic manipulation of gametes or zygotes outside the human body, contained in section 39A of the Human Tissue Act 65 of 1983. It is submitted that human cloning as described above will clearly amount to a contravention of this prohibition. (Jordaan DW 2000 *SALJ* 294, 303 contends that section 39A is “inapplicable” to cloning because of “vagueness”, but his argument is not convincing.)

In any event it may be argued that the placing of an embryo — albeit an embryo that has been “tampered” with — in the womb of a female with the purpose of reproduction falls within the definition of artificial fertilisation contained in the Human Tissue Act 65 of 1983. Such procedure will therefore be subject to the regulatory system of the Act, which is undoubtedly insufficient for regulating the procedure of cloning as such.

It may also be argued that cloning of human beings is *contra bonos mores* and that the consent of the person(s) involved would be invalid, so that any act by

a scientist involving the body of a living person might be said to amount “technically” to assault by common law.

The British government in June 1999 expressed itself against therapeutic cloning as well as cloning of people, the latter because it is “ethically unacceptable”. Legislation may be expected at some time in the future.

In August 2004 British scientists were given official permission to study how to clone early human embryos efficiently and use them as a source of stem cells purely for research purposes.

In its guidelines on ethics for medical research, published in 2002, the South African Medical Research Council (MRC) drew attention to the risks associated with current cloning technology. These risks are potentially harmful and even life-threatening to the embryo. The MRC accordingly recommended “that the use of human nuclear transfer cloning to create a new life should be prohibited” (MRC *Guidelines on Ethics for Medical Research* Book 2 (2002) par 3.4.4.1.2).

(Our discussion of genetic engineering in part 7.7 above is based largely on information obtained from the following sources: Oosthuizen GC, Shapiro HA & Strauss SA *Genetics and society* (1980) (paper by Jenkins T); Hatting J (ed) *Genetic engineering in ethical perspective* (1992), preface, and papers by Pretorius I and Retief A; Foundation BBV Documenta *Human Genome Project: ethics* (1992); WHO *Technical report series: control of hereditary diseases* (1996); *Proceedings: world congress on medical law* vol 2 (Sun City, 1996, (paper by Mangin P)); *Proceedings of the Second International Genome Summit* (1997); Goodwin JA & Meintjies-Van der Walt L “The use of DNA evidence in South Africa: Powerful tool or prone to pitfalls?” 1997 *SALJ* 151; *TIME* magazine (several issues); *The Weekly Telegraph* (several issues); MRC *Guidelines on ethics for medical research: Book 2 Reproductive biology and genetic research* (2002).)

ACTIVITIES

1. What are the permissible limits within which a pregnancy may be lawfully terminated?
2. There are many married couples who experience physiological problems when trying to conceive. Modern medical science has developed several methods of assisting couples to fulfil their desire. Name these methods and critically discuss the legality of each.
3. Genetic “engineering” (including genetic “manipulation”) is a relatively new technique devised by modern medical science. To a certain extent some of the methods used by geneticists are still in an experimental phase and raise difficult ethical and legal questions. What are these techniques or methods and what are the main ethical and legal issues that come to the fore?

— FEEDBACK —

1. The permissible limits of abortion, that is termination of pregnancy on medical, social and other grounds, are set out fully in the Choice of Termination of Pregnancy Act 92 of 1996 which we discuss fully in part 7.2 of this study unit. It is important to note that the gestational life of the foetus plays an important role in regard to determining (a) whether in a given case termination may take place, and (b) who would be entitled to perform the procedure.
2. Here we have in mind artificial insemination, embryo transfer and *in vitro* fertilisation, with the possibility of the couple availing themselves of a surrogate mother to give birth to the baby. Legislation in South Africa governs some of these procedures, but there are still unanswered ethical and legal questions with regard to surrogate motherhood.
3. In this study unit we have briefly explored the ramifications of genetic engineering. Our discussion is really no more than an introduction to this rather thorny subject. Our objective was to make you aware of some of the most important ethical and legal issues. In several countries the law is in a state of flux. However, already it is clear that whilst DNA “fingerprinting”, for example, has become acceptable, and there is a positive attitude towards gene therapy, the general attitude towards human cloning is very negative.

STUDY UNIT 8

Criminal liability of the doctor: murder and culpable homicide

Contents

- 8.1 Introduction
- 8.2 What is a “human being”?
- 8.3 Causal connection
- 8.4 Doctor in good faith supplies medicine to patient, who dies
- 8.5 Doctor supplies harmful substance to a suicidal patient
- 8.6 The degree of negligence
- 8.7 Culpable homicide: examples from case law
 - 8.7.1 Overdosage of medicine
 - 8.7.2 Blood transfusion to wrong patient
 - 8.7.3 Radiology: excessive amount of contrast medium
 - 8.7.4 Incorrect procedure during anaesthesia
 - 8.7.5 Failure of general practitioner to call in specialist
- 8.8 Other doctrines and offences
- Activities
- Feedback

Learning outcomes

- When you have completed this study unit, you should be able to
- understand the criminal liability of the doctor in respect of murder and culpable homicide

8.1 Introduction

Medical negligence may result in the death of a patient, leading to the doctor being found guilty of culpable homicide. Fortunately this occurs relatively seldom in our country. Occasionally a patient may die after having been medically treated, and the question may arise what the cause of his death was. In highly exceptional cases a doctor may even be found guilty of murder. As far as is known only one such case has been reported in South Africa. Today, however, the issue of “medical murder” has become relevant in connection with so-called “assisted suicide” which came to the fore in the modern euthanasia debate.

Although the emphasis in this study unit falls on medical doctors, the principles stated here are of equal application to other health-care workers.

Where a physician, by his unlawful conduct, causes a patient’s death, he may be guilty either of murder or of culpable homicide. It is interesting to note that several Roman authors, including jurists, mention the role that physicians have played in murder by poisoning! People who wished to get rid of their enemies (who were often their own relations) appealed to physicians for

assistance due to the fact that they knew so much about poisons. See Below G *Der Arzt im Römischen Recht* (1953) 122 *et seq*, and references cited.

In previous study units we have discussed topics which relate to these crimes, such as euthanasia, and will now expand this theme in more detail.

First we should note the definition of the two crimes. Murder is the intentional, unlawful killing of a human being; culpable homicide is the negligent, unlawful killing of a human being. The fundamental difference between the two offences lies in the element of *mens rea* (fault).

8.2 What is a “human being”?

The primary question in regard to both these offences is whether a human being has been killed. From the physiological or medical point of view there seems to be no problem here. In law, however, there is a problem, since the answer to the question can be of great importance. The unlawful and intentional destruction of an incipient life, that is, of a foetus — illegal abortion, in contravention of the Choice of Termination of Pregnancy Act 92 of 1996, in other words — is a less serious offence than the intentional killing of a person who is already recognised as a human being. The latter amounts to murder. Practical administration of justice, therefore, requires a definite criterion in respect of the stage at which the foetus becomes a human being. A satisfactory substantive criterion has, in South African law, yet to be found. Section 239 of the Criminal Procedure Act 51 of 1977 contains a procedural provision:

At criminal proceedings at which an accused is charged with the killing of a newly-born child, such child shall be deemed to have been born alive if the child is proved to have breathed, whether or not the child had an independent circulation, and it shall not be necessary to prove that such child was at the time of its death, entirely separated from the body of its mother.

The Native Territories Penal Code, Act 24 of 1886 (C), which previously applied in Transkei, required, on the other hand, that the foetus must have been completely separated from the body of the mother, and must, as such, have been in a living state. Section 134 of the Code stated as follows: “A child becomes a human within the meaning of this Code when it has completely proceeded in a living state from the body of its mother, whether, in a case of suspended respiration, it has breathed or not, and whether it has an independent circulation or not” (The provision was subsequently embodied in s 83 of the Transkeian Penal Code of 1983.)

The respiration test, which is set down in the Criminal Procedure Act, is in practice far more convenient than the requirement that the child must have “completely proceeded in a living state from the body of its mother”, because the latter test makes the proving of a “living state” necessary. As De Wet & Swanepoel 228 however rightly remarked, the Criminal Procedure Act criterion fails to solve the problem of when a foetus ceases to be a foetus, and the question persists, furthermore, whether proof that the child did not breathe would of necessity lead to the conclusion that it had been stillborn.

The general method which is used in order to determine whether the child was breathing is to establish whether the lungs will float on water. See Gordon I, Shapiro SD & Berson HA *Forensic medicine: a guide to principles* 3 ed (1988) 379. From a medical point of view the respiration test is not altogether satisfactory, since it is an acknowledged fact today that the foetus, before birth, does in fact carry out positive respiratory movements, as the process distends the lungs so that, if they are subjected to a microscopic examination, they reveal a close similarity with the lungs of a new-born child who has breathed. Moreover, the possibility of respiration by the foetus in the womb is evidently not to be altogether excluded; see Williams (21–22), relying on Simpson K *Modern trends in forensic medicine* (1953).

To complicate matters, Gordon et al (*op cit*) 379 mention “that cases have been recorded where respiratory movements were observed and infants were heard to cry although no portion of either lung would float”.

8.3 Causal connection

In both crimes — murder and culpable homicide — it is necessary to prove a causal connection between the act of the perpetrator and the death of the victim. The perpetrator need not have applied violence directly to the body of the deceased; to have brought about death indirectly, for example by acquiring the services of someone else to do away with the victim, is sufficient. Even the pre-natal injuring of a foetus by, for example, assaulting the mother, may, if the child dies after birth, make the perpetrator liable to conviction of either murder or culpable homicide.

8.4 Doctor in good faith supplies medicine to patient, who dies

A pertinent question is prompted here: If a physician merely supplies a patient with drugs or other potentially harmful substances, as a result of which the patient dies, can the physician be convicted of murder or culpable homicide? The administering of the medicine by the physician himself creates no problems, but here we are concerned with the act of supplying the medicine, in contradistinction to the act of administering it — a problem that has already been posed in connection with euthanasia.

In answering this question, the usual test for causation must be applied, that is whether, in accordance with the *dicta* of our courts, the death of the deceased is a reasonable and probable consequence of the perpetrator’s conduct, and not the result of a new, independent or intervening occurrence. If the medicine were made available in circumstances where the death of the receiver was not a likely consequence of such availability, then we accept that the existence of a causal connection will not readily be recognised by the courts. This would apply where, for example, the doctor in good faith supplies the patient with sleeping tablets to tide him over a severe emotional crisis, and the patient, instead of taking a single tablet at bedtime, as prescribed, takes all the tablets at once with the intention to take his own life. In this situation there is no fault (intention or negligence) on the part of the doctor.

8.5 Doctor supplies harmful substance to a suicidal patient

It is, however, another matter if the physician makes the harmful medicine available in circumstances which would make death a likely consequence, for example if the patient requests it expressly in order to commit suicide, or if the doctor encourages the patient to use it to commit suicide, or if the physician knows that it is potentially highly dangerous, but the patient thinks it is harmless. In such cases the existence of a causal connection ought, in our opinion, to be accepted, and the liability of the practitioner ought to depend on his fault or *mens rea*, which, in the circumstances quoted, may justify the inference of an intention to kill, or at the very least, negligence. Therefore, if the doctor foresaw that the patient might use the substance to commit suicide, and reconciled himself to such a possibility, the doctor **may** be guilty of murder. If the doctor did not foresee the suicide, or did not reconcile himself with such a possibility, but the reasonable person in his position would have foreseen it and would have taken steps to guard against such an occurrence, the doctor **may** be liable for culpable homicide.

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

It is likewise inadmissible to argue that, since suicide is not a crime in our law (see *R v Peverett* 1940 AD 213), it is not unlawful to assist a person to commit suicide. Joint causation of the death of another (in the absence of a ground of justification) is always unlawful. There is, from a socio-ethical point of view, a significant difference between an act intended to terminate one's own existence, and an act intended to terminate the existence of another. In the latter there is a positive disregard for the interests of another. (There are other conceivable circumstances in which negligence is present, for example where a physician makes poison available, thinking it to be harmless; here, the physician may at least be found guilty of culpable homicide.)

There are, however, indications in our case law which show that the supplying of a harmful substance to an intended suicide (the situation first quoted) is not punishable as murder or culpable homicide. Witness the case of *S v Gordon* 1962 (4) SA 727 (N), where, in the following factual situation, the accused was acquitted on a charge of murder: The accused and his mistress had entered into a so-called "suicide pact". The accused gave the woman drugs (15 Noludar tablets, and 8 Phanodorm tablets). She took the tablets and subsequently died. Her act (in taking the tablets) was, according to the court, an *novus actus interveniens*; the conduct of the accused was not the cause of her death.

In *R v Matthews* 1950 (3) SA 671 (N), on the other hand, the accused, in somewhat different circumstances, was found guilty of culpable homicide. The accused, in this case, supplied the deceased, who was already under the influence of liquor, with three glasses of sherry, and persuaded him to drink them in quick succession. As a result of this the deceased died. The accused, who was the employer of the deceased, exercised, according to the court, a certain degree of authority over him, and the conduct of the accused did in

fact constitute the administering of the alcohol. It is clearly shown by the case of *Matthews* that persuasion or encouragement to imbibe a harmful substance can in fact constitute the necessary causal connection.

The decision in *Gordon* was, in our respectful opinion, open to criticism, and the perpetrator, as we have said above, should have been found guilty of murder, or at least of culpable homicide. See Strauss SA “Staat v. Gordon, 1962 (4) S.A. 727 (N)” 1963 *THRHR* 57. It is in any case almost inconceivable that a court, in circumstances where a physician was the provider, would arrive at the same conclusion, since a physician, by virtue of his profession, finds himself in a position of trust.

Gordon cannot be considered authoritative any longer, in view of the decision of the Appellate Division in *Grotjohn* 1970 (2) SA 355 (A), supporting the view that a person who assists another in committing suicide may in certain circumstances be guilty of murder or culpable homicide. In this case the Appellate Division made it clear that if a person (X) supplies another (Y) with the means to commit suicide, the mere fact that the last act causing Y’s death (the act of suicide) is Y’s own voluntary, non-criminal act does not necessarily break the chain of causation set in motion by X. It may be added that in the latter case the furnishing of a firearm was at issue, not the supplying of drugs. However, in principle there is no difference. See also Van der Merwe NJ “*S v Eldred William Grotjohn*, Saak Nr. 418/68 (W)” 1969 *THRHR* 187; Hugo JH “To kill a mocking bird — murder or suicide?” 1969 *SALJ* 148; *S v Hibbert* 1979 (4) SA 717 (D).

It is interesting to refer to a text from the *Digesta*, D 9.2.9 pr, in which the issue in point is touched upon. This text tells us that in the opinion of the Roman jurist, Labeo, a midwife who administers medicine to a woman, from which she dies, is, if she has administered the medicine with her own hand, to be held as having killed. If, however, the midwife merely gives the medicine to the woman, and the woman takes it herself, with fatal results, then the midwife, according to Labeo, has furnished a cause of death, rather than killed. Therefore, as Labeo explains, the *actio in factum* is granted. (This text concerns the extension of the *Lex Aquilia* to cases for which there is no express provision in the wording of the *Lex*.)

The legal issues involved in a doctor’s assisting a severely suffering patient with a terminal illness who wishes to end his own life, have drawn worldwide attention in consequence of the actions of a Dr Jack Kevorkian in Michigan USA during the 1990s. Kevorkian, a vehement protagonist of “planned death” — and dubbed by the media “Dr Death” — developed an apparatus which could be connected to the patient by way of an intravenous needle. If the patient pushed a button, an anaesthetic substance would be fed by the apparatus into his bloodstream, followed by potassium chloride which would result in 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 (see Strauss SA “Legal liability for doctor assisted suicide” 1991 (4) *SA Practice Management* 12). Legislation soon followed, as well as further prosecutions, but Kevorkian challenged the constitutionality thereof. The American Supreme Court is still to rule on the matter.

In 1999 Kevorkian — who had by that time assisted 130 suicides — was charged with murder once again, following his giving an ailing patient who desired to die a lethal dosage of drugs. Kevorkian 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 legalise doctor-assisted suicide within certain narrow limitations. A few cases were publicised, but the Australian federal parliament soon stepped in and nullified the state legislation.

In the late 1990s the SA Law Commission made certain recommendations concerning passive euthanasia which would also have included legislation on what may be termed doctor-assisted suicide within the limits set by the Commission. So far nothing has come of these recommendations. The Commission's final report was tabled in Parliament at the beginning of 2000.

Doctor-assisted suicide remains a highly controversial issue in most societies, but it is said that it has become a fairly general practice in, for instance, the Netherlands. In 2001 the Dutch parliament passed an Act which declares doctor-assisted suicide in extreme cases lawful. The requirements are very strict. *Inter alia* the doctor must be satisfied that the patient's suffering is unbearable and that there is no prospect of improvement. Such cases must afterwards be officially reported and will then be assessed by a review committee. Other countries that have legalised assisted suicide within limits are Belgium and Switzerland.

8.6 The degree of negligence

The question whether a person who has unlawfully caused the death of another will be found guilty of murder or culpable homicide, depends on the form of *mens rea* proved in respect of the consequences. If only negligence is proved, the accused will be guilty of culpable homicide. Barlow TB 1948 *THRHR* 173, at 190 suggested that a physician should be prosecuted for having caused a person's death through negligence only in cases of gross negligence ("where one feels a sense of shock"), and not in cases where the physician's negligence was slight ("mistakes which may be little more than a slip"). In *R v T v d M* 1953 *Journal of Forensic Medicine* 68 an English case was used as support when arguing on behalf of a physician who was charged with culpable homicide, namely that a person cannot be convicted of criminal negligence unless his negligence was of a gross nature. The court, however, per Roper J rejected this view:

It is not our law; the basis of our law in this country is the Roman-Dutch law, and it is not part of our law that a person, whether professional or not, can be found guilty criminally only if he is guilty of gross negligence. In our law the test of negligence is exactly the same in civil as in criminal cases In our law a man is liable criminally for negligence whether his negligence is gross or slight.

(On medical negligence in general, see Claassen NJB & Verschoor T *Medical negligence in South Africa* (1992); Carstens PA *Die strafregtelike en deliktuele*

aanspreeklikheid van die geneesheer op grond van nalatigheid LLD thesis, University of Pretoria (1996).)

8.7 Culpable homicide: examples from case law

In South Africa physicians have, in various cases, been found guilty of culpable homicide. These cases bring important principles to the fore, and practical guidelines for doctors may be found in the judgments. In your study of these cases you should concentrate on the essential facts and principles, and the reasons advanced for the judgments.

We now briefly discuss some of these cases.

8.7.1 Overdosage of medicine

R v Van Schoor 1948 (4) SA 349 (C): Dr V, a young doctor, joined Dr R on 2 February as his assistant. On 9 February Dr E, another assistant of Dr R, had to treat a number of syphilis patients. E was busy, however, and he requested V to carry out the treatment, the injection of a new serum, Neo-Halarsine, which contained arsenic. V had little or no experience of the substance. When E asked V to treat the patients, V apparently asked E what he ought to do, E failed to realise that V knew nothing about the drug, and he merely pointed to a shelf where it was stored with other medicines, and told him to “take an ampule, mix it with 9 cc of water, and that is the maximum dose”. E was under the impression that the ampules contained 0,09 grams. Other cartons had, however, been placed on the shelf without his knowledge, and each ampule in these cartons contained ten times this amount. On the outside of each dose appeared a description of the mixture and the dose contained in the ampule; each box contained instructions on how to use the mixture. V did not read the instructions, and administered, by intravenous injection, the contents of each ampule to all the patients. Two of the patients died as a result of the overdose. The court ruled that V had been negligent, and found him guilty of culpable homicide.

R v Van der Merwe 1953 (2) PH H124 (W) (fully reported as *R v T v d M* in 1953 *Journal of Forensic Medicine* 68): The accused, a general practitioner, was consulted by a seventy-year-old woman. She gave a history of an old “whiteleg” on her left side, and of a femoral thrombosis she had had a short time before, and which, apparently, had not yet cleared up. An examination by the physician revealed that active thrombosis was still present.

The doctor decided to treat her condition with Dicumarol, and supplied her with the following prescription: “Mrs ... Dicumarol, 40 tabs One t.d.s.p.c.”. The pharmacist who received the prescription from the patient was unable to contact the physician; he consulted the *British Pharmacopoeia*, and gave the patient 40 tablets of 100 mg strength. The patient consumed 38 tablets (3 800 mg) in a period of 13 days. The first indications of bleeding became noticeable eight days after she had begun taking the tablets. Three days later her gums and a sore between her shoulders began to bleed. Two days later the doctor was informed of her condition by telephone. He instructed her to stop using the tablets, but did not visit her or prescribe any other treatment.

Her condition continued to deteriorate, with bleeding from the mouth and

bladder, and other grave symptoms. The patient's husband informed the physician of the symptoms, and the physician gave instructions for the administering of Vitamin K. There was no improvement, and, since the physician was not available, his colleague was summoned. He had the patient removed to a nursing home. In spite of blood transfusions and Vitamin K injections, the patient died shortly afterwards. The doctor was charged with culpable homicide, and the prosecution alleged seven grounds of negligence. *Inter alia* it was alleged that he had failed, before administering and prescribing the medicine, to acquaint himself with the strength and dosage in which it ought to have been prescribed.

On behalf of the doctor it was argued that, when he wrote the prescription he had a dosage of 25 mg in mind, which was to have been administered three times a day (which, according to medical evidence, would have been harmless). It was also submitted that a doctor is entitled to expect a pharmacist to telephone him if he (the doctor) has failed to mention the dosage. On this point the judge, in his summary, declared the following to the jury: "It appears to me to be a very alarming suggestion that a doctor who is supposed to have superior knowledge should be entitled, if he makes a faulty prescription, to shelter himself behind the pharmacist who makes it up. You must ask yourself whether it is not his duty to issue a prescription in such a form that the pharmacist will not make a mistake." The jury found the doctor guilty.

S v Mkwetshana 1965 (2) SA 493 (N): The accused was a young qualified doctor who was doing his internship at a hospital for twelve months. One of the female patients was suffering from bronchial asthma. She received treatment and when her condition improved, was discharged. There were, however, certain problems in connection with her return home since she stayed far away, and therefore she remained in hospital over the Easter weekend. On Good Friday morning a staff nurse noticed that the patient was restless and was finding it difficult to breathe.

The only medical officer available in the hospital (or in the particular section of the hospital) at the time, was the accused. When he arrived at the patient's bedside she was kicking convulsively, waving her arms. Her lips and tongue had a blue tinge and she was foaming at the mouth. The accused diagnosed a serious form of acute asthma. He ordered 20 cc of aminophylline — a recognised drug for the treatment of asthma — and administered it intravenously. After five or seven minutes there was no improvement.

Then it occurred to the accused that the attack might be epilepsy, and he decided to try paraldehyde. He administered 20 cc of the drug intravenously. The patient's condition improved and he left her. However, she died a quarter of an hour later; it appeared that 20 cc of the latter drug was an overdose. The recognised intravenous dosage, according to scientific evidence, should not have exceeded 5 cc; even then, it should have been diluted with a solution of sodium chloride in the proportion of one to ten.

The accused was found guilty on a charge of culpable homicide. On appeal it was argued, *inter alia*, that, since he was an intern, comparatively inexperienced, and confronted with an emergency, he could not be charged with negligence; he did his very best, it was submitted, in the emergency: he

could not have been expected to remember the safe dosage, as laid down, and he did not have an opportunity to consult textbooks, or to appeal to his seniors.

The court of appeal rejected this contention, however, and Caney J held as follows:

[E]ither the appellant had insufficient knowledge and experience of the drug, in which case it was negligence on his part to administer it in the manner in which he did administer it; if he knew little, if anything, about it he was subjecting his patient to a very considerable risk ... for him to have done that, in the light of his inexperience, and particularly his inexperience of this drug and its uses, marks him as having been negligent.

The judge pointed out that information on the use of the drug in question was freely available, both in medical textbooks used by students and elsewhere. He continued: “There can be no excuse for a medical man, even though just setting out on his career, if he neither knows these doses and uses, nor troubles to have them available to him.” In the circumstances the judge held that the accused should have contacted one of his seniors, even telephonically, or he should have obtained assistance from one of the staff nurses. The conviction was therefore confirmed.

8.7.2 Blood transfusion to wrong patient

In *S v Berman* (1996 TPD, unreported) a medical practitioner was convicted of culpable homicide as a result of a blood transfusion performed upon the wrong patient. Dr N, a specialist gynaecologist, had on the same day performed operations on two of his patients, who bore the same surname and were in the same clinic, although in different parts. Unlike other hospitals which are divided into wards, this hospital was divided into sections, and the sections into wards.

The deceased, Mrs HV, received a blood transfusion before or during the operation. In the case of Mrs EV, Dr N directed that an urgent blood transfusion be performed after conclusion of the operation. A requisition and a blood specimen were sent to the J Blood Transfusion Service, of which the accused was an operator. In the application form a space was to be filled in under the word “ward”.

There the word “one” was inserted, but the word “ward” was not deleted and the word “section” not substituted. After the usual blood tests had been performed, two bottles of blood were handed to the accused by a technologist. Because the latter was aware of the subdivision and practice of the clinic in question, he wrote the patient’s name as well as “ward one” on the labels attached to the bottles.

When the accused arrived at the clinic he did not proceed to Section One but made enquiries at the reception desk, where he was directed to the wrong patient, Mrs HV, in Section Eight. There the accused enquired of the sister whether the patient was Mrs V, Dr N’s patient, to which the sister answered in the affirmative. The accused did not consult the bed letter of the deceased, on

which was the name of HV (in large, legible letters), neither did he ask the deceased any questions to identify her.

He thereupon set up the transfusion apparatus and left. Shortly afterwards Dr N came to see the patient and he stopped the transfusion. The damage caused by the incompatibility of the infused blood was stopped, but upon a diagnosis of internal bleeding (a diagnosis which proved to be erroneous) a further transfusion of blood under pressure was given to the patient. This led to an overload of the heart and the patient died of heart failure. The court (upon appeal) held that the accused

... knew that the transfusion of blood into the wrong patient was in 99 per cent of cases the same as the injection of a potential killer poison into the patient's veins. Based on his previous extensive experience the [accused] set out on what he knew or should have known to be a most hazardous mission if any mistake should be made. He knew or should have known that after certainty had been reached about the quality of the blood to be administered, the accurate identity of the recipient was paramount.

The court therefore held that the accused was properly convicted of culpable homicide in that he had failed to identify the deceased as being the patient who was to receive a blood transfusion.

8.7.3 Radiology: excessive amount of contrast medium

In S v Bezuidenhout 1987 (1) SA Practice Management 27 (A) the accused, Dr B, a radiologist, performed a radiological examination on a six-week-old baby boy for a urological problem. An intravenous contrast medium, Urografin, was administered and a number of X-rays taken. Shortly afterwards the child developed convulsions that would not cease. He was treated in the children's ward of the hospital and was later transferred to an intensive care unit where he died five days later.

Dr B and the radiographer who assisted him were charged with culpable homicide in the regional court and convicted. The magistrate found that the cause of the convulsions and subsequent death had been an overdose of contrast medium, administered negligently by the accused. Upon appeal to the Supreme Court the radiographer's conviction was set aside but that of Dr B confirmed. B appealed to the Appellate Division.

In the Appellate Division it was argued on behalf of B, on the basis of the evidence of one of the expert witnesses, that the convulsions could have been due to either of the following:

- (1) an overdose
- (2) hypersensitivity for the contrast medium used
- (3) a congenital tendency of the child to develop epilepsy

It was contended that in respect of the latter two possibilities even a normal dosage of the contrast medium could have resulted in convulsions.

The Court found that it had been proved that about 125 ml of the contrast medium had been administered to the child, a quantity which far exceeded the maximum dosage of 30 ml on which the experts were agreed. The

contention that it was possible that there was no causal relationship between the overdose and the convulsions was rejected by the Court. According to one of the expert witnesses she had not experienced a single case of allergy over a period of 12 years in which 2 400 babies had been given the contrast medium.

As far as the possibility of a congenital tendency towards epilepsy was concerned, the Court pointed out that the State pathologist's evidence had not been challenged, namely that if the epilepsy had been triggered by a normal dosage of urografin, it would have been brief and controllable.

The conviction was confirmed.

8.7.4 Incorrect procedure during anaesthesia

In *S v Kramer and Another* 1987 (1) SA 887 (W) a relatively inexperienced anaesthetist worked with a surgeon during a tonsillectomy and adenoidectomy performed on a ten-year-old child. The anaesthetist anaesthetised the patient and the surgeon asked, and was given, permission to proceed with the operation. The surgeon then started to remove the left tonsil. The anaesthetist had failed to insert an endotracheal tube correctly. The patient became cyanosed and the surgeon noticed this. He continued to remove the left tonsil and then, with the aid of a laryngoscope, came to the conclusion that the tube was not in the trachea (windpipe). He immediately ordered further doses of fabantol and scolene (drugs used in connection with anaesthesia), removed the tube and reintubated the patient with another tube. The patient was ventilated and her colour improved. She suddenly became cyanosed again and as no pulse was palpable, cardiac massage was started. Attempts were made to stimulate the patient's heart with a defibrillator (an apparatus that delivers an electric shock) but to no avail. The patient died in the theatre.

In the magistrate's court both the surgeon and the anaesthetist were convicted of culpable homicide. The surgeon was found to have been negligent in that he

- should have ensured that the endotracheal tube had been correctly inserted by the anaesthetist — the court *a quo* found that this duty on the surgeon arose as a result of the following:
 - he knew that the anaesthetist was a relatively inexperienced anaesthetist
 - he knew that every anaesthetist can place an endotracheal tube wrongly
 - he admitted at the inquest that had he checked if the tube had been correctly placed, the deceased's death could have been avoided
- should not have removed the left tonsil after he had seen that the patient had become cyanosed — in doing so he delayed commencing the resuscitative measures
- should not have ordered the anaesthetist to inject more scolene, a drug that would paralyse the lungs of the patient and prevent her from breathing normally

The court *a quo* found the anaesthetist to have been negligent in that he

- should not have relied on the sister to choose an appropriate length of endotracheal tube, as it was possible that the tube which was inserted was too short or that it was not inserted deep enough into the trachea
- did not insert the tube into the trachea at all
- did not monitor the patient's condition adequately and therefore did not timeously detect that the supply of oxygen to the patient's lungs was inadequate
- should not have frozen at the first signs of a crisis, as he was busy with a dangerous undertaking and the patient's life was in his hands

The Court of Appeal held that in general neither the surgeon nor the anaesthetist is liable for the other's negligence. This general rule will, however, be subject to exceptions, for example where the surgeon knew that the anaesthetist was incompetent or not in a fit condition to perform his duties. There may also be other exceptions. The court was of the opinion that there was no duty on the surgeon to have looked down the trachea of the patient to check the position of the tube before commencing the operation. The court rejected the court *a quo*'s conclusion that the surgeon should not first have completed removing the left tonsil before commencing resuscitative measures. The half-cut tonsil was bleeding profusely into the very area of the deceased's throat into which somebody had to look to see whether or not the tube had been correctly placed. The court found that the magistrate was wrong in finding that the surgeon was at fault to have ordered the anaesthetist to inject more scolene. In order to insert a new tube, a muscle relaxant (such as scolene) was necessary. The court came to the conclusion that the surgeon, when faced with the extreme emergency, had acted swiftly and reasonably in trying to create an airway, and took all reasonable measures to resuscitate the deceased under the prevailing circumstances.

The Court held that the anaesthetist had been negligent in failing to insert the tube correctly and in failing to monitor the patient properly, by which the misplacement of the tube could have been discovered.

8.7.5 Failure of general practitioner to call in specialist

In *S v Nel* 1988 (1) *SA Practice Management* 7 Dr N, a general practitioner, was attending to a woman when she gave delivery to her third child. Immediately after the birth of the child Dr N experienced problems with the removal of the placenta (afterbirth) from her uterus. The patient bled profusely and died later the same evening from loss of blood and shock.

It appeared that the patient had been admitted to a maternity home at about 11:45 that day for her confinement. By 17:45 the doctor was called to the maternity home. He regarded it as necessary for the purposes of the confinement to conduct surgery, and carried out a left lateral episiotomy (a cut through the labia). The baby was delivered at 18:45. Complications set in, however, in that the placenta remained behind in the uterus. Dr N tried by application of the Brandt-Andrews method to deliver the placenta, but had no success. He proceeded to make several attempts to remove the placenta by hand, but these were also in vain.

The patient's husband, H, was present, and observed that the doctor was apparently experiencing serious problems and that in the meantime his wife

was suffering tremendously. Later H testified in court that shortly after the birth of the child Dr N had pushed his hand into the patient's vagina and pulled on the umbilical cord so that it broke and blood splashed all over a nursing sister. A heated argument between the doctor and the sister followed. Thereupon the doctor twice inserted his hand into the patient's vagina up to his elbow and kept it there on each occasion for approximately 30 seconds.

All Dr N's attempts to remove the placenta were to no avail, and by 19:00 Dr N left the maternity ward. Mr H learnt from the matron that there was a specialist on the premises. H came across Dr N outside the maternity ward and told him of the specialist. Dr N's reaction, however, was to tell H that he was "not a monkey" and that he would call in a specialist should he be in need of one.

Between 19:00 and 19:20 H was informed by Dr N that he had called in an anaesthetist. The anaesthetist arrived at 19:40 and noticed that there had already been a massive loss of blood. He established that no blood specimen had been taken, that no blood plasma had been ordered, and that no intravenous infusion of fluid had been started.

The anaesthetist immediately took the patient's blood pressure, commenced an intravenous infusion and administered anaesthesia by means of pentothal (sodium thiopentone). Only at this stage did N at the request of the matron agree to call in a specialist, Dr S, with the remark that "a second opinion would do no harm". To the knowledge of Dr N, Dr S had already been in the maternity home since about 19:00 and had been available, should N have required his assistance.

Accordingly it was only at a relatively late stage, at 20:10, that Dr S arrived in the maternity ward and started attending to the patient. He removed the placenta tissue and began to suture the episiotomy incision which had remained unsutured up to that stage. Before he could complete this, the patient died, at 20:20.

Dr N was charged in the regional court with culpable homicide. The court found that he had been negligent in several respects. Amongst other things he had failed to take proper blood-pressure measurements, to do a necessary intravenous infusion before endeavouring to remove the placenta by hand, to take a blood specimen and to order blood, to call in a specialist obstetrician in spite of a request to that effect made by the patient's husband, and to rub the uterus in order to let it contract. He had made unsuccessful and unskilful attempts to remove the placenta whilst valuable anaesthetic time had been lost, and he had left the maternity ward at a critical time. The court held that the accused's negligence had been the cause of the patient's death.

On appeal to the Transvaal Provincial Division of the Supreme Court, it was contended that it had not been proved beyond a reasonable doubt that an omission on the part of Dr N had been the cause of the patient's death. A specialist anaesthetist had testified during the trial that the administration of pentothal and halothane by the anaesthetist could have caused the patient's death. However, the court rejected this argument with the following comment: "This sort of statement is not of real value. Anything can happen. One sometimes reads that the taking of aspirin can cause death. That does not say a thing" (our translation).

What the witness ought to have done, according to Eloff J, if he had wanted to make an objective scientific contribution to the court's task, was to explain how real the possibility had been that administration of these substances could have caused death. It is difficult to avoid the impression, the judge observed, that the expert witness "simply took a shot in the dark" to try and help the accused. The court accordingly confirmed the magistrate's verdict.

However, the court held that the sentence imposed by the regional court — five years' imprisonment, of which three years were conditionally suspended — was excessively heavy. The accused's failure to call in a specialist was no more than a reprehensible error of judgment, and did not constitute recklessness. The facts of the case pointed rather to clumsiness and a lack of skill. A sentence of a fine of R5 000 with the alternative of a sentence of two years' imprisonment, coupled with a suspended sentence of two years, was accordingly substituted.

The Appeal Court subsequently refused to grant the doctor leave to appeal.

8.8 Other doctrines and offences

There are a number of subjects relating to the practice of medicine which could lead to criminal liability, but we do not cover them in this module. These are, *inter alia*, attempt, participation and complicity, assault and *crimen iniuria*.

ACTIVITIES

1. A patient is chronically ill and constantly suffers severe pain. She consults a doctor, who prescribes three types of medication: two strong painkillers and a sleeping tablet. The patient is advised to take one capsule of each of the painkillers when she awakes in the morning, and again by 19:00. The doctor recommends that she take one sleeping tablet at night if she is unable to sleep. The patient tells the doctor: "Doctor, I assume that I will die if I took all these tablets at once", to which the doctor responds: "Yes, of course."

Some days later the patient in a fit of depression on account of the pain and sleeplessness takes all the remaining tablets in one dosage. She becomes comatose and her domestic servant finds her in that state early the next morning. The patient is taken to hospital by ambulance, but the emergency staff is unable to resuscitate her, and she dies.

Can the doctor on the basis of these events incur criminal liability? Discuss.

2. A doctor prescribes medicine to be taken in the form of 10 mg tablets three times daily to a patient. Inadvertently the doctor writes "20 mg" on the prescription instead of "10 mg". The pharmacist who dispenses the medicine is aware that the usual dosage is 10 mg and that a dosage of 3×20 mg may have dangerous side-effects if taken by the patient for any length of time. However, the pharmacist assumes that "the doctor knows what he is doing" and accordingly does not check the dosage with

the doctor. The patient takes the medicine as prescribed and develops very severe side-effects 12 days later, in consequence of which he dies.

Can the doctor on the basis of these facts incur criminal liability? Discuss.

FEEDBACK

1. It is inconceivable that the doctor can incur criminal liability in these circumstances. There is no intent on his part to cause any harm to the patient, nor is there any negligence in answering the patient's question. There was no indication on the part of the patient that she contemplated to end her life by taking a heavy overdose of medicine. This can certainly not qualify as a form of assisted suicide. Had the patient told the doctor that she intended to commit suicide and he then indicated that an overdose would bring about death, the conclusion may be different.
2. The doctor made a mistake in prescribing a double-strength dosage of medicine. The conclusion is almost inescapable that he was negligent in so doing. If expert evidence were adduced that such a dosage is likely to result in death and not merely in side-effects of a passing nature, the element of causation would also be established, justifying a finding of culpable homicide. The potential liability of the pharmacist is a different question, but the doctor can certainly not find refuge in the failure of the pharmacist to query his (the doctor's) prescription.

STUDY UNIT 9

Delictual liability

Contents

- 9.1 Introduction
- 9.2 Intentional conduct
 - 9.2.1 Medical treatment without consent
 - 9.2.2 Invasion of privacy
- 9.3 Medical negligence
 - 9.3.1 The concept of negligence
 - 9.3.2 The standard of care
 - 9.3.3 The proof of negligence
 - 9.3.4 Proof of causal connection
 - 9.3.5 Vicarious liability
 - 9.3.5.1 Introduction
 - 9.3.5.2 Relationship of employment
 - 9.3.5.3 What is a servant?
 - 9.3.5.4 Scope of employment
 - 9.3.5.5 Direct hospital liability
 - 9.3.5.6 Employer's right of recovery
 - 9.3.6 Waiver by patient of future claim for possible negligence ("disclaimer")

Activities

Feedback

Learning outcomes

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

- distinguish between liability on the part of a doctor (or other health-care provider) for intentional wrongdoing and negligent misconduct
- understand the need for patient confidentiality and to assess potential liability for breaches of the duty of health personnel to maintain confidentiality
- understand the legal standard set for assessing medical negligence, and the problems of proof experienced by aggrieved patients who want to recover damages for alleged medical negligence
- understand the concept of vicarious liability and appreciate its importance in enabling aggrieved patients to sue employers for the negligence of their staff

9.1 Introduction

As opposed to a crime which is an unlawful act that may result in conviction and sentencing of the perpetrator in a criminal court, a delict is a civil wrong

which is not punishable as such, but may result in a verdict by a (civil) court that the wrongdoer must pay damages to the injured party. A delict may be described as the act of a person that in a wrongful and culpable way causes harm to another (see Neethling et al 3). All five the requirements or elements of a delict must be present before the conduct complained of may be classified as a delict. These requirements are (1) an act, (2) wrongfulness, (3) fault (or culpability), (4) harm and (5) causation.

A doctor, a health-care professional or a health-care provider such as a hospital owner may incur delictual liability in consequence of wrongful conduct which has harmed a patient if that conduct was accompanied by fault in the form of either intent or negligence.

9.2 Intentional conduct

9.2.1 Medical treatment without consent

Medical treatment without the informed consent of the patient *prima facie* constitutes an assault and will be wrongful unless justified by some other ground of justification, such as *negotiorum gestio* or statutory authority (see our discussion in study unit 5).

In *Broude v McIntosh and Others* 1998 (3) SA 60 (SCA) (the facts were discussed briefly at 5.3.1 above), where a doctor was sued by a patient for assault on the basis of alleged lack of informed consent, the Supreme Court of Appeal in a full-bench judgment (per Marais JA) expressed the following reservations:

Pleading a cause of action such as this as an assault to which the patient did not give informed consent is of course a familiar and time-honoured method of doing so. However, I venture to suggest with respect that its conceptual soundness is open to serious question and merits reconsideration by this Court when an appropriate case arises. To the average person, and I suspect to many a lawyer, it is a strange notion that the surgical intervention of a medical practitioner whose sole object is to alleviate the pain or discomfort of the patient, and who has explained to the patient what is intended to be done and obtained the patient's consent to it being done, should be pejoratively described and juristically characterised as an assault simply because the practitioner omitted to mention the existence of a risk considered to be material enough to have warranted disclosure and which, if disclosed, might have resulted in the patient withholding consent. It seems to me to be inherent in the notion that, even if the risk does not eventuate and the surgical intervention is successful, the practitioner's conduct would nonetheless have constituted an assault. That strikes me as a bizarre result which suggests that there is something about the approach which is unsound. There is no principle of law of which I am aware by which the characterisation as lawful or unlawful of an intentional act objectively involving the doing of bodily harm to another can be postponed until its consequences are known. Either it was an assault at the time of its commission or it was not. Events occurring *ex post facto* can logically have no bearing on the question. It is no answer to say that if the undisclosed risk does not

eventuate no damage will have been caused. That has nothing to do with the characterisation of the medical practitioner's act in intervening surgically as lawful or unlawful. I mention this merely by way of example to explain why I consider that the validity of causes of action framed in this *manner in circumstances similar to those which are said to exist in this case* requires re-examination. (I emphasise the latter qualification; I leave aside cases in which *mala fides* is involved such as cases of deliberate fraud and deliberate misrepresentation of what is entailed in order to obtain consent which would otherwise not be forthcoming.) However, re-examination would be inappropriate in the present case. The matter was not argued and even if it be assumed in favour of appellant that the cause of action based upon an allegation of assault is conceptually sound in law, I agree with the trial Judge's conclusion that the evidence does not bear it out.

See our comment on this case in study unit 5.3 above.

See also *Pop v Revelas* 1999 (WLD unreported) discussed in study unit 5.2.1 above.

9.2.2 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 as well as an ethical nature. In terms of the ethical rules of conduct made by the Health Professions Council of South Africa (and published in GN R717, GG 29079 of 4 August 2006) a medical practitioner may only divulge information regarding a patient which he or she has to divulge in terms of a statutory provision, at the instruction of a court of law, or where justified by public interest (rule 13(1)). Rule 13(2) prohibits the divulging of information which ought not to be divulged in terms of rule 13(1), except with the express consent of the patient, or, in the case of a minor under the age of 14, with the written consent of his or her parent or guardian, or, in the case of a deceased patient, with the written consent of his or her next-of-kin or the executor of such deceased patient's estate (rule 3(2)).

An actionable invasion of a patient's privacy will result in the doctor incurring liability under the *actio iniuriarum*. The principles relating to violation of privacy will not be discussed here in any detail. Suffice it to say that a doctor can escape liability only if he can advance a recognised ground of justification, such as the patient's consent or public interest.

An important judgment of the Appeal Court on violation of privacy was *Jansen van Vuuren and Another NNO v Kruger* 1993 (4) SA 842 (A). This case deals with a doctor's duty towards his patient who has AIDS. The court stressed the legal nature of a doctor's duty to respect the confidentiality of his patient. The duty is nevertheless not absolute but relative: a doctor could be justified in disclosing his knowledge of the patient's HIV status where the doctor's obligations to society were of greater weight than his obligations to the individual. But on the facts of the case before it, the court ruled that the doctor's disclosure was not justifiable.

The appeal was against the judgment of the Transvaal Provincial Division of

the Supreme Court, denying a claim for damages by Mr M, a patient with AIDS, against Dr K. M alleged that Dr K had, in breach of a duty of confidentiality owed to him as his patient, disclosed to others the test results of his HIV status.

The essential facts of the case were as follows: M had lived in a homosexual relationship with one V in the Transvaal town of B. They were fairly well-known residents of the town and the nature of their relationship was either generally known or surmised. During 1990 they began a business venture and moved to another Transvaal town, retaining some links with B. M applied for life insurance and had to submit to the usual medical examination, including a test for HIV. M nominated Dr K to prepare the medical report. A blood sample was taken and the laboratory informed the doctor that the test was positive. Dr K arranged for an appointment with M in order to consult with him on the outcome of the test. M was extremely upset and distressed. He was also concerned about a possible leak, and raised the issue with Dr K, who promised to respect his wish to keep it confidential.

The following day, in the course of a game of golf with Dr X, also a general practitioner, and a dentist, Dr K disclosed Mr M's condition to them. M and these three doctors moved in the same social circle in the town of B. M was engaged in a business venture with Dr X's wife. M had in the past been a patient of the dentist. Dr K's ex-wife and her parents were on friendly terms with V. The news spread and M became aware of this fact. M was annoyed and took steps to establish the source of the breach of confidence. In due course he sued Dr K for R250 000 damages. He alleged a breach of a term of the agreement which established the doctor-patient relationship, and also contended that the disclosure of the test result amounted to an invasion of his rights of personality and his right to privacy. Dr K denied making the alleged disclosure; alternatively, he pleaded that the disclosure had been justified in law, *inter alia* on the grounds that it was made on a privileged occasion and that it was the truth and in the public interest.

During the trial Dr K testified that the dentist had been his patient and Mr M's dentist. He (Dr K) was therefore concerned that M might have infected the dentist. He felt obliged to inform the dentist of M's condition to enable him to evaluate his own exposure to the virus. It was not, however, his intention to discuss the matter with him at the stage when they played golf. Nevertheless, Dr K testified, in the course of the game a general discussion about HIV-infection had taken place, and in order to stress the immediacy of the problem, he told his two golf partners that he had a patient, known to all of them, who had tested positively. Dr X then remarked that he wondered whether it was not M, since he had consulted him about an oral fungal infection. K confirmed the correctness of Dr X's surmise and asked him to treat the information confidentially.

K's evidence was accepted by the trial court. Although the Appeal Court had some reservations about this finding, the latter court assumed its correctness for the purposes of its decision. The trial court had found that the disclosure was legally justified. As far as K knew at the time of the disclosure, Mr M was still the dentist's patient, and was likely to be treated by him in future. As concerned his colleague, X: he was one of a group of 16 doctors in B who

were on call from time to time for all off-duty practitioners in town. In the view of the trial judge it was required that he should be informed for his own sake, as well as for the better treatment of M, should the occasion arise.

The Appeal Court — consisting of five judges — took a different view, though. In its judgment it drew attention to the fact that M had moved to another town. The likelihood of him calling on either the dentist or Dr X was remote. “If the argument is taken to its logical conclusion,” the court stated, “health-care workers, at least those in Transvaal, would have to be informed.”

In determining whether Dr K had a social or moral duty to make the disclosure, and the other two doctors had a reciprocal social or moral duty to receive it, the standard of the reasonable man applies. With that in mind, the court ruled, there had been no such duty. True, the court said,

AIDS is a dangerous condition. That on its own does not detract from the right of privacy of the afflicted person, especially if that right is founded in the doctor-patient relationship. A patient has the right to expect due compliance by the practitioner with his professional ethical standards ...

In this case, the court emphasised, the expectation had been even more pronounced because of the express undertaking by Dr K. The court concluded that communication to Dr K’s colleagues had been “unreasonable and therefore unjustified and wrongful”.

In the event, damages in the amount of R5 000 were awarded by the Court of Appeal, and Dr K was ordered to pay costs. (It is to be noted that Mr M had died prior to the conclusion of the trial, and that it was the executors of his estate who had lodged the appeal. The damages recovered would therefore have been credited to the deceased’s estate.)

This judgment is perhaps the most emphatic judicial ruling in South Africa stressing that medical confidentiality is not merely a matter of professional ethics but also a legal duty, the breach whereof may result in legal liability. As the court pointed out, per Harms AJA, the law protects a person’s *dignitas*, and *dignitas* embraces privacy. “In the present case we are concerned with the alleged invasion of [the right to privacy] by means of a public disclosure of private facts.” The court drew attention to the ancient origin of the doctor’s duty to maintain confidentiality:

As far as the public disclosure of private facts is concerned, the Hippocratic Oath, formulated by the father of medical science more than 2 370 years ago, is still in use. It requires of the medical practitioner “to keep silence” about information acquired in his professional capacity relating to a patient, “counting such things to be as sacred secrets”. But the concept even predates Hippocrates.

In this context the court quoted a reference to a work written in Sanskrit and presumed to be from about 800 BC, in which Brahmin priests were advised to carry out their medical practices by concentrating only on the treatment of the patient and not divulging any information about the sick person to anyone else. In ancient Egypt also the priestly medical men were under strict oaths to retain the secrets divulged to them in confidence. They worshipped in the

temples of Isis and Serapis, healers of the sick, and also of their son Horus, who was usually called Harpocrates by the Greeks and was pictured with his finger held to his mouth. The name used for medicine, *ars muta* (dumb art) was used in Roman poetry by Virgil. The Pythagorean school in Greece, to which medical practitioners in particular belonged, considered silence as one of the most important virtues.

The Appeal Court also made specific reference to the ethical rule of the SA Medical and Dental Council regarding professional secrecy, and its 1989 guidelines on AIDS. The judgment again indicates what importance the courts attach to ethical viewpoints of a professional body such as the Council (now replaced by the Health Professions Council of South Africa).

9.3 Medical negligence

Apart from any contract between doctor and patient, the doctor owes the patient a duty of care when performing an operation or giving treatment, which implies that the procedure will be performed with the requisite professional skill to avoid injuring the patient. Failure to do so amounts to a delict or civil wrong, entitling the patient to claim damages (*Correia v Berwind* 1986 (4) SA 60 (Z)).

The delictual liability of the doctor for negligence is a subject which has enjoyed considerable attention in the courts. We do not intend discussing this subject in detail. We do, however, draw your attention to important principles which you should know and study for examination purposes.

9.3.1 The concept of negligence

It is trite law that negligence refers to the blameworthy attitude or conduct of someone who has acted wrongfully. The blameworthiness is to be found therein that on account of carelessness, thoughtlessness or imprudence the person failed to adhere to the standard of care legally required of him. See Neethling et al 116. In the case of an expert, such as a doctor, negligence is established by finding an answer to the question how a **reasonable expert (doctor)** would have acted in the same circumstances.

In a 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 was not performed in a negligent manner. In *Richter and Another v Estate Hamman* 1976 (3) SA 226 (C) the court indicated that such failure could constitute negligence. This view, however, was rejected in no uncertain terms by a full bench of the same court in a subsequent decision, *Castell v De Greef* 1994 (1) SA 408 (C). Ackermann J said that in South African law “the issue is treated not as one of negligence, arising from the breach of a duty of care, but as one of consent to the injury involved and the assumption of an unintended risk”.

The essential facts in *Castell* were the following: In 1982 Mrs C underwent surgery for the removal of lumps in one breast. In 1989 further lumps were diagnosed. In view of Mrs C’s family history, her gynaecologist recommended a mastectomy as prophylaxis, and referred her for this purpose to Dr D.

When first consulting Dr D, Mrs C and her husband discussed the operation

with him at some length. What was proposed was a surgical procedure involving the removal of as much breast tissue as possible, with simultaneous reconstruction of her breasts using silicone implants.

The operation was performed some two months later. Breast tissue was removed bilaterally. A 280 ml prosthesis was implanted on each side behind the pectoral muscle, and the areolae and nipples were repositioned.

It was well known that the operation was attended by a high risk of complications, particularly necrosis of the skin and underlying tissue, including the areolae and nipples. Complications did in fact set in, in the form, *inter alia*, of discoloration of the skin and *staphylococcus aureus* infection. Mrs C required medical treatment for a considerable period afterwards, including further surgery, which resulted in medical costs and psychological trauma and pain.

On appeal the court found that the patient had been adequately apprised of the inherent risks, particularly those involved in the transposition of her areolae. The court also held that the doctor's failure to quantify the degree of risk — in the form of a complication rate — by mentioning a figure of 50 per cent was not a material nondisclosure. The doctor had therefore complied with the criteria for informed consent laid down by the court.

The appeal court did, however, find against the doctor on the issue of negligence. It ruled that the patient had proved that she had developed post-operative sepsis in her breasts, of which the doctor became aware, and that the organism, or one of the organisms, causing the sepsis was resistant to the antibiotics which had been prophylactically prescribed by the doctor. The doctor had been negligent in not timeously taking a pus swab and sending it for analysis. Had that been done, an appropriate antibiotic would have been prescribed sooner.

But it was impossible on the evidence to establish that the doctor's negligence had played any role at all in the harm ultimately suffered. The patient was entitled, however, to be compensated for the additional period — twelve days — of pain, suffering, illness, discomfort and anxiety she had to endure because of the doctor's failure to treat her infection properly and timeously. Damages in the amount of R7 500 were accordingly awarded and an order of costs made in favour of the patient.

9.3.2 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**. This principle was reaffirmed in *Buls and Another v Tsatsarolakis* 1976 (2) SA 891 (T). The plaintiff, a bricklayer, tried to start the engine of a concrete mixer. The engine backfired and the starting handle struck his right wrist. He went to the hospital where he was examined by the casualty officer on duty, Dr B. X-rays were taken but Dr B found no evidence of a fracture.

On a second visit to the hospital, Dr B communicated to the plaintiff that since his first visit the hospital's part-time radiologist had examined the X-ray plates but had not found any fracture. Subsequently the plaintiff consulted a

private specialist orthopaedic surgeon, who referred him for X-rays, and these revealed a fracture of the scaphoid bone of the right wrist.

At the trial the specialist testified that in his opinion Dr B was negligent in that at the second visit he had failed to immobilise the plaintiff's wrist. Another specialist testified, however, that there was no neglect of duty by Dr B. His conduct was that which would have been expected from an ordinary casualty officer. Dr B was not an expert in problems of the type which had arisen, and he had given them the attention of a general practitioner. The court held that the plaintiff had failed to establish negligence. A factor in the decision was the finding of the trial court that at the second visit Dr B had told the plaintiff that he should come back if he continued to experience pain. This the plaintiff had not done.

The principle that reasonable skill and care are required, and not a higher degree, was reaffirmed in *Castell v De Greef* 1994 (1) SA 408 (C). (The decision also highlights issues pertaining to informed consent.) See also *Roos v Sinclair* [2004] All SA 299 (NC). In the latter case the court also 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 practises be a factor in assessing whether the doctor has complied with the required standard of skill and care? In the USA the so-called “locality rule” evolved many years ago, whereby the locality indeed played a role. In *Van Wyk v Lewis* 1924 AD 438 Wessels JA made the following statement:

[Y]ou cannot expect the same skill and care of a practitioner in a country town as you can in a large hospital in Cape Town or Johannesburg. In the same way you cannot expect the same skill in these towns as you will find with the leading surgeons in the large hospitals of London, Paris and Berlin. It seems to me therefore that the locality where an operation is performed is an element in judging whether or not reasonable skill, care and judgment have been exercised.

In the same case, however, Innes CJ took the opposite view and held that the same degree of care is required wherever the doctor may practise.

South African legal writers generally support the latter view and draw attention to factors such as 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, and information distributed by pharmaceutical companies about medicine.

Carstens PA “The locality rule in medical practice” 1990 *De Rebus* 421, however, argued, convincingly that a distinction should be drawn between the subjective abilities (such as skill, education and knowledge) and the objective circumstances in which the accused finds himself in a particular locality. He argued that a lack of medical facilities and infrastructure should be considered in the assessment of his conduct.

We support Carsten's view. In *Collins v Administrator, Cape* 1995 (4) SA 73

(C) the court in fact held that when it concerns a claim against a hospital authority for harm suffered by a patient in consequence of the negligence of its staff, a standard of excellence which is beyond its financial resources cannot be expected. (In the *Collins* case a 16-week-old child sustained permanent brain damage because of cerebral hypoxia when a tracheotomy tube which supplied him with air was displaced. It appeared that on account of a shortage of nurses in the provincial hospital, a nurse was not near the child at the critical time when he suffered a lack of air. A nurse who then arrived did notice that the child was in distress, but could not manage to replace the tube, and the court held that she had been negligent.)

9.3.3 The proof of negligence

The ordinary rule concerning the burden of proof is that such burden rests with the plaintiff. Because expert evidence is needed in the overwhelming majority of medical cases, the plaintiff usually finds it difficult to acquit himself of the burden. Often the best the plaintiff can hope for is to find an expert who can interpret for the court occurrences at and in connection with the medical intervention and its consequences.

We draw your attention here to a single factor, namely whether in endeavouring to prove negligence, the plaintiff may rely on the evidentiary principle of *res ipsa loquitur* (“the thing speaks for itself”). This means that merely by proof of the harmful event and the fact that it was caused by an object which was in the exclusive control of the defendant, a *prima facie* factual presumption of negligence on the part of the defendant arises. True, the plaintiff will not be relieved of the *onus* which he bears, but if the defendant does not succeed in offering an acceptable explanation for what happened, the court may readily come to the conclusion that he has been negligent. The principle is often invoked in negligence cases (see Schmidt CWH *Bewysreg* 3 ed (1990) 163 *et seq.*).

Our courts have displayed a marked unwillingness to apply the *res ipsa loquitur* doctrine in cases of alleged medical negligence. The leading case is *Van Wyk v Lewis* 1924 AD 438. Following a surgical operation there was a failure to remove a surgical swab from the patient’s body, with painful consequences. The court refused to find that the doctor was negligent on the basis of *res ipsa loquitur*. Wessels JA said the following:

The mere fact that a swab is left in a patient is not conclusive of negligence. Cases may be conceived where it is better for the patient, in case of doubt, to leave the swab in rather than to waste time in accurately exploring whether it is there or not, as for instance where a nurse has doubt but the doctor after search can find no swab, and it becomes patent that if the patient is not instantly sewn up and removed from the operating table he will assuredly die. In such a case there is no advantage to the patient to make sure that the swab is not there if during the time expended in exploration the patient dies. Hence it seems to me that the maxim *res ipsa loquitur* has no application to cases of this kind.

In *Pringle v Administrator Transvaal* 1990 (2) SA 379 (W) a claim resulted from a bronchoscopy followed by a mediastinoscopy performed on a 63-year-old woman by a senior registrar, Dr S, who had been employed by the

defendant hospital authority. The patient had had a history of carcinoma and had undergone a mastectomy (removal of breast gland) 29 years earlier. She presented with opacity of the right lung, and an investigation of the lung was necessary. (A bronchoscopy is an examination of the bronchus, a large air passage in the lung. A mediastinoscopy is an examination of the mediastinum, that is the tissue separating the two lungs.)

In the course of the mediastinoscopy the patient's superior vena cava (the major vein emptying into the right atrium of the heart) was torn, causing torrential bleeding. The mediastinum was packed. The patient lost approximately two litres of blood, and a right thoracotomy (a surgical incision of the wall of the chest) was performed to repair the damaged vena cava. On the day following the operation she went into acute renal failure and required haemodialysis (mechanical purification of the blood).

The patient suffered brain-damage as a result of the operation, and she claimed that this had resulted in permanent damage to her eyesight and permanent inability to work. She also underwent personality and character changes. After the operation her employment was terminated summarily by her employer.

The court found, however, that Dr S had been negligent in tearing the superior vena cava while attempting to biopsy the lymph-node in the gland adjacent thereto. In cross-examination it was put to Dr S that he had "tugged" at the lymph-node and pulled the vena cava. His answer was: "In retrospect I would say that I tugged too 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," she said, "by showing merely that the occurrence happened ... or by showing after it happened how it could have been prevented".

The judge continued as follows:

I am mindful too of all the pressures and the tensions which operate on a surgeon at a time like this. However, in the light of all the evidence and the only possible explanations as to how the perforation of the vena cava and the mediastinal pleura occurred, I am driven to find that on this particular aspect, and by using the "excessive force" which he concedes, Dr S did not apply that skill and diligence possessed and exercised at the time by the members of the branch of the profession to which he belonged.

As a result, damages in the amount of R92 483 were awarded to the plaintiff. The judgment reaffirmed the view taken in *Van Wyk v Lewis* that there is no room in this type of case for application of the doctrine of *res ipsa loquitur*. Observed Blum AJ: "The maxim could only be invoked where the negligence alleged depends on absolutes."

Van den Heever P *The application of res ipsa loquitur to medical negligence cases: a comparative survey* LLD thesis University of Pretoria (2002) argues that constitutional principles support the extension of the doctrine to this type of case in South Africa.

9.3.4 Proof of causal connection

In our discussion of criminal-law aspects above we said that a causal connection has to be proven in materially defined crimes (crimes, that is, where the emphasis is on the consequence brought about and not so much on the act itself). The same applies when a claim based on a delict is brought, and proof of negligence in causing a harmful result through a medical intervention is required.

In *Pearce v Fine and Others* 1987 (3) SA *Practice Management* 14 (D) the widow of a patient who had died in the course of a radiological examination brought action for damages against radiologists practising in partnership on hospital premises.

The deceased was a 54-year-old male who had experienced problems with micturition. His doctor, suspecting prostatitis (inflammation of the prostate gland) referred him to the defendants for a radiological examination of his kidneys, bladder and urinary tract. Such an examination is known as an intravenous pyelograph: while lying on an X-ray table the patient is injected with a chemical substance called a contrast medium. Thereafter X-ray exposures of the area of the body containing the organs mentioned are taken at intervals of approximately five minutes. Contrast medium is injected into the bloodstream so that better pictures of the internal organs may be taken.

The procedure was commenced by G, a radiographer, taking control X-ray photographs for the purpose of comparison at a later stage. Having perused the developed photographs, Dr L injected the contrast medium, after the usual exploration and test dosage. When the solution was injected the patient experienced a hot flush, an alien taste and a feeling of nausea (common reactions experienced by patients undergoing this test). After a few minutes Dr L left the X-ray room. G then proceeded to expose the required series of X-ray films. When this had been done, she left the patient and took the X-ray films to the darkroom for processing. The darkroom is approximately eleven paces from the door of the X-ray room. She left the film with the darkroom attendant and returned to the X-ray room.

When G returned, she found the patient unconscious and breathing stertorously, that is with a snoring sound. She hurriedly summoned Dr L and an emergency team from the hospital's intensive care unit. Resuscitative measures were applied to the patient without success, and he died.

The court accepted G's evidence that when she left the patient she did so in the *bona fide* belief that his state of health gave no cause for alarm, and that she was absent from the X-ray room for less than two minutes. Dr L testified that when he examined the patient after being summoned by G, he diagnosed cardiac arrest. He immediately started resuscitation procedures. The intensive care team applied defibrillation (delivering an electric shock to "restart" the heart). The very first shock produced normal sinus rhythm, but the heart relapsed into ventricular fibrillation (an irregular quivering contraction of the lower chamber of the heart). A second and third shock were delivered with the same result. The fourth shock was to no avail.

Expert witnesses were in agreement on the probable cause of death: the injection had produced a drop in the patient's blood pressure (caused by the

patient's anxiety or by the toxic effect of the ingredients of the contrast medium, or by both these factors). The deceased's heart had been unable to pump sufficient blood and had gone into ventricular fibrillation, which could not be effectively reversed.

It was alleged that Dr L had been negligent in that he had left the presence of the patient without satisfying himself that it was safe to do so, or in that he had failed to take steps to ensure that G would remain with the patient until it was safe to leave him. It was further alleged that G had been negligent in that she had left the patient unattended before it was safe for her to do so.

The court found that it was unnecessary to make any finding on the question of negligence. **Even if there had been negligence, it had not been established that such negligence was causally connected to the patient's death.** On a conspectus of the evidence relating to causation, the court was of the opinion that the plaintiff had failed to establish, on a balance of probability, that the patient's life would have been saved had he been kept under constant observation and had resuscitation commenced as soon as he displayed symptoms of distress. There was evidence that the patient's heart had been overweight by some 30 to 80 grams. The fact that the heart is overweight usually means that there is some disease of the heart. An expert witness was of the opinion that the deceased might have suffered from cardiomyopathy, which is a weakness of the heart muscle. There was also some atheroma in the coronary artery. (Atheroma is a deposit of fatty tissue inside the artery, which usually causes some degree of narrowing of the artery.)

There was expert evidence that, all in all, the chances of survival after cardiac arrest are very poor. The experts' experience had not shown that if one could start resuscitation early one could bring the patient round, and he would then survive. Starting resuscitation at the first wave of ventricular fibrillation does not guarantee a successful result. Even under the best circumstances, however early one gets there, one is dealing with a very lethal condition. The death rate where defibrillation is administered within the first four minutes is between 86 and 92 per cent. The difference in the survival rate between treatment in minute one and minute four after cardiac arrest is very slight, according to one observer (in the order of approximately 13,5 per cent as compared to approximately 6 per cent).

The case illustrates how difficult it may be to prove a causal nexus between an alleged medical omission and the death of a patient in these cases.

See also *Silver v Premier of the Gauteng Provincial Government* 1998 (4) SA 258 (W). In this case the patient S was admitted to a provincial hospital for treatment of pancreatitis (inflammation of the pancreas). By the time that he was discharged, his ability to walk properly had been permanently impaired. He sued the hospital authority on the basis of alleged negligence causing a pressure sore (bedsore) which became infected and which resulted in necrotising fasciitis (ie death of binding tissue in his body) and ultimately paralysis of the lower limbs. It appeared that S, when admitted to the hospital, was obese, a diabetic, had to be dialysed (ie his blood had to be purified mechanically) — which gave risk to a fluid leak — had a temperature and was hypotensive (ie suffered from low blood pressure).

According to expert evidence on the “constellation” of risk factors predisposing a patient to the development of bedsores, P had a “full house” of these factors.

Evidence was led by the defendant that the standard of nursing care received by P in the hospital had measured up to the required standards. The court came to the conclusion that there had been no proof of a causal connection between any act or omission on the part of the hospital staff. On the probabilities of the case the sacral bedsore which the patient was likely to have developed, would not have remained superficial, and polymicrobial infection would have taken place.

The court (per Cloete J) stated as follows:

Assuming, therefore, that the pressure sore on the plaintiff’s sacrum was caused by the negligent omission of the nursing staff in the general surgical ward to give proper pressure part care (a question which I find unnecessary to decide), and assuming further that the plaintiff’s disability resulted from a polymicrobial invasion which spread from the bedsore (a question which I find unnecessary to decide), the plaintiff is not entitled to the damages which he has claimed — as, on the probabilities, and given that the plaintiff’s hypothesis as to how his disabilities occurred is correct, he would have suffered such damages irrespective of any negligence on the part of the nursing staff in the general surgical ward and, for all practical purposes, at the same time.

In *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* [2002] 1 All SA 384 (SCA) a 17-year-old youngster underwent corrective nasal surgery after a sports injury. During the operation a too low dosage of anaesthetic led to the patient going into cardiac arrest. The nurse had some difficulty in operating a defibrillator in an attempt to normalise the heart. The patient suffered serious and permanent brain damage. On the facts of the case the court found that **even if there had been no delay in the use of the defibrillator, the brain damage would have been unavoidable**. The quantity of cocaine used in the anaesthetic was within the acceptable limits. There was no negligence on the part of the anaesthetist. Even if the clinic had instructed its staff properly on the use of the defibrillator, the timeous use thereof could not have prevented the mishap.

On the proof of a causal nexus, see also *Roos v Sinclair* [2004] 1 All SA 299 (NC).

9.3.5 Vicarious liability

9.3.5.1 Introduction

The principle of indirect or vicarious liability, that is liability for the wrongful act of another by virtue of the doctrine of *respondeat superior*, is well established in the modern law of delict. First, a person can be held delictually liable if he **ordered or authorised** another to commit a wrongful act. Thus a doctor who instructed his professional assistant to perform an unlawful operation cannot later seek refuge in the excuse that he did not perform the operation with his own hands.

As far as liability for negligence is concerned, authorisation to perform a negligent act will probably seldom occur. The question of vicarious liability will ordinarily arise in those cases where a person employs another to perform a lawful activity, and the employee then does not proceed with the required or expected measure of skill and care, and causes harm to others. As far as the medical situation is concerned, the potential liability of the doctor for the negligence of his professional assistants and the nurses he employs is relevant, as well as the possible liability of a hospital authority for the negligence of doctors, nurses, paramedics and other personnel it employs.

9.3.5.2 Relationship of employment

The general principle is that there must be a relationship of employment whereby one person (the master or employer) stands in a position of authority *vis-à-vis* another (the servant or employee) in terms of which the former is legally capable of exercising control over the latter's actions. Partners do not stand in such a relationship: by law they are equals, even though the one may be the senior of the other. It is nevertheless generally accepted that one partner is vicariously liable for the wrongful act of another when such act falls within the scope of partnership business — *Lindsay and Others v Stofberg* NO 1988 (2) SA 462 (C); *Mdletshe v Litye and Another* 1994 (3) SA 874 (E).

A person is not vicariously liable, however, 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 particular as concerns the method applied. He is not a servant but “his own master”. In the medical context the anaesthetist who collaborates with the surgeon performing an operation ordinarily is such an “independent contractor” (see eg *S v Kramer and Another* 1987 (1) SA 887 (W)), as is the case with the specialist to whom a general practitioner refers his patient or who is called in on the case. Provided that the surgeon (or general practitioner) on reasonable grounds believes that the anaesthetist (or specialist) is professionally competent to do the job, there is no question of liability on the part of the former. If the practitioner who refers the patient is not so convinced, he may be held liable on account of his own negligence. (This principle is reminiscent of the ancient Roman form of vicarious liability, *culpa in eligendo* — fault through a poor choice of servant.)

An independently practising doctor who “hires” an operating theatre in a hospital is not an employee of the hospital. The hospital can, therefore, not be held liable for his negligence. But the hospital may incur direct liability for its own negligence, for example where a patient operated on by such a doctor suffers harm caused by defective theatre equipment, which is the hospital's property.

The doctor or nurse who is a member of the staff of a hospital, in other words, who occupies a firm and fixed position, is a servant of the hospital authority, and the latter will be delictually liable for acts of professional negligence committed by the servant within the scope of his or her employment.

In *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T) the court held

that a hospital authority was liable for the unskilful professional acts of a doctor employed by the hospital (excessive X-ray treatment of a patient suffering from a sarcoma, resulting in necrosis which necessitated the amputation of both her legs and the left hand). In *Dube v Administrator, Transvaal* 1963 (4) SA 260 (W) the court held that the hospital authority was 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 which resulted in a Volkmann's contracture (on account of the plaster having been applied too tightly). They failed to notice this, and ultimately the patient's arm had to be amputated. Trollip J in his judgment referred to "negligence on the part of the hospital", and drew attention to the fact that it was not disputed in the case that "the Hospital was liable for any negligence by those of its servants who treated and attended the patient".

In *Mtetwa v Minister of Health* 1989 (3) SA 600 (D) the patient had been treated in a hospital in Durban for suspected tuberculosis. The physician who treated her was an employee of the hospital authority concerned. It was alleged that the doctor had acted carelessly in prescribing a particular medicament for her, in consequence of which she suffered a series of unpleasant and harmful after-effects and side-effects. She sued for damages in the amount of R10 000. In his judgment Nienaber J pointed to an earlier principle of law that a member of the professional staff of a hospital was not a "servant proper" for whose misdeeds the hospital could be held liable.

The judge stated as follows:

Nowadays, I venture to suggest, the question is purely one of fact. The degree of supervision and control which is exercised by the person in authority over him is no longer regarded as the sole criterion to determine whether someone is a servant or something else. The deciding factor is the intention of the parties to the contract, which is to be gathered from a variety of facts and factors. Control is merely one of the *indicia* to determine whether or not a person is a servant or an independent worker.

The judge made the following interesting comparison:

Just as, these days, the Minister of Law and Order can be held accountable for the peccadilloes of a policeman even when the latter exercised a discretion of his own, indeed, even if he was not on duty, so too, it might be argued by analogy, the Minister of Health is at risk if a member of the staff of a hospital under his command is negligent in the exercise of any of his duties, be they professional and not subject to dictation from others.

In the event the patient was held to have a legal and valid cause of action.

9.3.5.3 *What is a servant?*

The modern rule clearly is far more equitable than the earlier approach. In so far as there is a choice, there are certainly powerful arguments to be advanced in favour of vicarious liability to be on the broad side rather than being too narrow. To mention only a single consideration from the point of view of

public policy: the consequences of a simple act of negligence may be of catastrophic dimensions to the patient, and apart from injury to his body and disfigurement, may take the form of a substantial pecuniary loss. When that runs into hundreds of thousands — or millions — of rand, the patient's chances of recovery against a hospital authority may be far better than against the negligent doctor or nurse, who in legal phraseology may be “a man of straw”.

It cannot be argued that the modern rule is casting the net of liability too wide. The courts have over the years laid down a number of common-sense limitations on vicarious liability. Thus the courts have generally been at pains not to unduly broaden the concept of what a “servant” is.

It was held in the Transvaal (in *Hartl v Pretoria Hospital Committee* 1915 TPD 336) that a doctor who at the request of a hospital authority 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 in South Africa not to be the servants of the doctor. (In England the view is taken that the hospital authority will remain vicariously liable for the negligence of its servants in such a case, notwithstanding the fact that they are temporarily under the control of the independent doctor. In the USA, however, the courts have ruled that the visiting doctor — and not the hospital — is liable for such “borrowed servant” by virtue of the “captain of the ship” parallel, but this doctrine, although receiving initial support in South Africa, was emphatically rejected by the Appellate Division in its 1924 decision in *Van Wyk v Lewis* 1924 AD 438.)

In the USA the situation in regard to hospital liability has been somewhat complicated by the fact that emergency-room medicine is becoming a separate speciality. What is the position of the hospital where the emergency service is run not by the doctors in full-time employ, but on contract by an “outside” partnership? Strictly speaking the outside doctors would seem to fall within the category of “independent” contractors. Most American courts initially held that the negligence of such “contract” doctors will not render the hospital vicariously liable. However, these decisions are being questioned. More and more states are beginning to realise that contract doctors for emergency rooms are in the public mind employees of hospitals, and this has led to decisions in some states whereby the hospital authorities were held liable.

No South African court has as yet been confronted with this problem. Here emergency services were in the past rendered exclusively by state hospitals and not by private hospitals. But towards the end of the twentieth century the situation began to change radically. Today many private hospitals — big and small — offer 24-hour emergency services. These services are offered on hospital premises by groups of privately practising doctors for their own account and not as employees of the private hospitals. Should the issue of vicarious liability arise in respect of a mishap occurring in such a “Med-24” facility, a court will probably rule that because the hospital authority has neither actual physical control over the actions of the contract doctor, nor the right to so control the doctor, the hospital cannot be held liable vicariously.

9.3.5.4 *Scope of employment*

Today the notion of “scope of employment” is regarded as wider than before. The emphasis seems to have shifted from actual control, in the form of instructions to and actual supervision of the servant’s actions, to the right of control. According to some authorities it is sufficient to establish that the servant is a member of the “organisation” of the employer. The question must be asked, so it has been suggested, whether the employer exercised control over the “where” and the “when”, rather than the “how”. The test which a court will apply in this regard in the ultimate analysis depends on considerations of public policy. The American view in regard to the contract doctor in the emergency room goes very far and would seem to imply that “course of employment” also includes the impression of that concept prevailing in the mind of the general public. It is doubtful whether a South African court will go so far. In 1978 the Appeal Court ruled (not in a medical context, though) that “the element of control has always been regarded as a factor of prime importance in determining the existence or otherwise of a master and servant relationship ...”, but the court appears to have been satisfied in this case that the master would be liable if the alleged servant in the “**manner**” of performing the act in question “**could** lawfully receive directions” from his superiors (*Mhlongo and Another NO v Minister of Police* 1978) (2) SA 551 (A), our emphasis).

In *Mtetwa’s* case (*supra*) the court emphasised that the degree of control exercised by persons in authority over him is not the sole criterion “to determine whether someone is a servant or something else”. The deciding factor is the intention of the parties to the contract, which is to be gathered from a variety of facts and factors. Control is merely one of the indications.

The South African courts have so far clearly guarded against the notion of scope of employment — although already very wide in modern industrial society — being broadened to such an extent that it becomes a meaningless fiction. There is no indication that our courts are moving towards absolute or strict liability, that is, the notion whereby a hospital authority would automatically be liable for the negligence of any professional, whether employed or not, who makes use of its facilities.

There are some indications in decided South African cases that the question whether the employee has acted within the scope of his employment may be judged on the basis of the creation of a risk of harm by the employer (see eg *Feldman (Pty) Ltd v Mall* 1945 AD 733; *Minister of Police v Rabie* 1986 (1) SA 117 (A)).

What is the position of the non-paying patient or the patient in a hospital? Will the hospital authority be vicariously liable for negligence on the part of an employee? In South Africa it was held that the patient need not be a paying patient in order to have a right of recovery (*Dube supra*). The hospital involved was a state institution. This is also the position in England. In the USA there have been decisions to the effect that a non-profit hospital was immune against liability in the case of non-paying patients, but the more recent trend is clearly in favour of liability. It has also been held in the USA — on the basis of the ancient principle that “the King can do no wrong” — that a State hospital cannot be sued, unless it has waived its immunity. Statutory

exceptions have been made in the case of federal hospitals in a number of states.

9.3.5.5 *Direct hospital liability*

We have drawn attention above to the possibility of a hospital authority incurring direct liability for its own negligence, that is, not via the conduct of an employee. Hospital liability on the basis of “corporate negligence” does not fall within the ambit of this chapter. It is convenient at this point, however, to draw attention to the notion of “direct liability”.

As Giesen D *International medical malpractice law* (1988) 59 has observed, there is a clear trend towards greater hospital accountability in both common law and civil law jurisdictions. “The development of a new approach to the liability of hospital authorities,” he says, “has probably deprived of most its practical significance the point of whether in a given case a hospital may be held vicariously liable for the negligence of staff or independent contractors operating on its premises.” He draws attention to a 1986 English decision where the opinion was expressed that there is “no reason why, in certain circumstances, a health authority could not be directly liable to a plaintiff if it failed to provide sufficient or properly qualified and competent medical staff for the unit.” He also cites a 1980 Australian case in which the view was taken that a case could be made that the hospital in question was an institution which, by admitting a patient, undertook to render complete medical services through its staff. As Giesen remarks, on this basis it makes no difference whether an independent contractor (a specialist, a visiting consultant or a concessionaire) can be brought under the traditional head of “servant” or not.

It is certainly not inconceivable that a South African court could arrive at the conclusion that a particular hospital authority undertook to provide such an all-embracing service. But whether there has been breach of contract or negligence will depend on all the circumstances and the evidence before the court in a given 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, etcetera.

It should be stated, however, that in a country such as ours, with a serious epidemiological problem and a growing shortage of skilled medical staff, the courts will no doubt adopt a conservative stance and not expand medical liability to an unreasonable extent.

Although a person is not vicariously liable for the wrongful act of an independent contractor engaged by him, the circumstances may be such that an actionable duty may arise for the employer himself to take steps to prevent harm to members of the public, for example, where the owner of a building engages a contractor to do work on the building, and harm to passers-by is foreseeable unless the area of operations is cordoned off or warning signs erected — *Langley Fox Building Partnership (Pty) Ltd v De Valence* 1991 (1) SA 1 (A); *Minister of Community Development and Another v Kock* 1991 (3) SA 751 (A). This is not vicarious liability; the employer is held liable on the basis of his own negligence — liability is, therefore, direct.

9.3.5.6 Employer's right of recovery

An employer who was held liable for the negligence of an employee acting within the scope of his employment, is entitled to recover the damages paid to the plaintiff from the erring employee. The employee himself is in any event also personally liable to the injured party.

(For the references to foreign cases referred to in this section, see Strauss 299 *et seq.*)

9.3.6 Waiver by patient of future claim for possible negligence ("disclaimer")

May a doctor, hospital or other health-care provider protect him- or itself against liability for possible negligence in treating the patient or for some other form of malpractice by having the patient sign a waiver of claims, an indemnity form or a so-called "disclaimer" prior to the intervention?

Many private hospitals in South Africa nowadays have waiver clauses in their admission or consent forms which they require patients or their parents, guardians or wards to sign prior to treatment. These clauses may vary in their wording. Generally they seek to protect the hospital against mishaps occurring in connection with nursing or handling the patient. Some of these clauses are formulated in very wide terms, purporting to protect the hospital and its staff against claims based even upon gross negligence, recklessness or intentional acts performed by hospital staff. (There is no legislation in South Africa on the subject of such indemnity clauses. It is doubtful whether the current legislation on harmful trade practices would be at all applicable in this regard.)

We have never come across a 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. Our opinion, so far, has been that such contracts would probably be void (unenforceable) because they would offend against public policy (or *boni mores*, in the sense of the juristic notions of society) and "unconscionable" in the terminology sometimes used by the courts. A waiver by a patient safeguarding a doctor against liability for negligence, so it would seem, would be tantamount to a patient "licensing" a doctor to practice bad medicine.

In this connection it should be noted that there is nothing in our law preventing a patient after a claim — in legal terminology a "cause of action" — had arisen, to agree with the doctor or hospital to settle the claim or to abandon it in part or altogether, provided that the patient did so voluntarily and not under duress or undue influence. In South Africa the overwhelming majority of cases involving claims of patients against doctors or hospitals are settled out of court.

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. If clearly worded, they are upheld as perfectly valid. See eg *Government of the Republic of South Africa v Fibre Spinners & Weavers (Pty) Ltd* 1978 (2) SA 794 (A). In *Durban Water Wonderland (Pty) Ltd v Botha and Another* 1999 (1) SA 982 (SCA) a disclaimer protecting an amusement park against liability for injuries sustained by a mother and child when flung from a defective

mechanical device resembling a small jet aircraft mounted on a kind of merry-go-round, was likewise upheld as valid.

So far we have never had a case in our courts involving a waiver of liability by a patient for a potential claim against a negligent doctor. (There is, however, an *obiter dictum* in a case, *Edouard v Administrator, Natal* 1989 (2) SA 368 (D) 385E, suggesting that a doctor could “contract out of liability” towards the parents of a child who was born to them after an unsuccessful sterilisation. But there is no indication in the judgment that this would be possible where there had been negligence on the part of the doctor.) However, a judgment was handed down by the High Court in 1999 which to our knowledge was the first of its kind involving a **hospital**. The case is *Burger v Medi-Clinic Ltd* 1999 WLD (unreported as yet).

In this case the patient sued the hospital owner for damages in the amount of R1 061 114 flowing from the nursing staff’s alleged negligence or gross negligence. The patient had been admitted to the hospital in 1966 to undergo a haemorrhoid operation. The day after the operation the patient vomited a blackish liquid and experienced nausea, faintness, dizziness, sweating, yawning and motionlessness. He was pale and his breathing was shallow. The patient later alleged that the nursing staff had failed to take reasonable steps to prevent him from suffering a vasovagal syncope (fainting on account of extreme anxiety), falling and injuring himself. He maintained that the staff, with full knowledge of his symptoms, discharged him from hospital without first contacting his doctor. The patient attempted to go to the bathroom on his own, lost consciousness and fell heavily, fracturing his right cheekbone. There was consequent concussion, pain, depression and permanent disfigurement.

In their plea the hospital denied most of the patient’s allegations except for admitting that they had failed to inform him that he should not leave his bed and walk on his own. They also denied all liability. As a special defence the hospital relied on an indemnity clause in the operation consent form. In terms of this clause the patient consented to an anaesthetic and a specified operation by a specified doctor. By signing the consent form the patient “therefore” indemnified the hospital owner as well as its employees against “all liability to such patient ... for any loss or damage which originates from any cause whatsoever”. Prior to the hearing of the case the parties agreed that the word operation meant “the actual surgical procedure in the theatre”. It was further agreed that the incident which gave rise to the patient’s damage had not been caused by any negligent act in the theatre.

On behalf of the patient it was argued in court that the clause indemnified the hospital only in respect of the actual surgical procedure in theatre, and that the patient’s loss was caused by conduct unrelated to the surgical procedure. It was further argued that the indemnity clause did not protect the hospital in respect of gross negligence on the part of its employees and that, in any event, the clause was *contra bonos mores* (against public policy) and therefore void. Snyders J ruled, however, that the view that the document entitled “consent to operation” only deals with aspects relating to the actual operation or surgical procedure to be performed in theatre, was untenable. The use of the word “therefore” in the document suggests that as a result of

the consent to the operation, the need has arisen for the indemnification. “The consequence of the consent to the operation is not only the surgical procedure in the theatre itself, but also admission to the clinic and the treatment whilst there,” the judge said. The specific wording refers to the owner of the clinic and “all their employees, officials and agents”, without limitation, which would include those in the wards tending to the patient after the actual surgical procedure in the theatre. In addition, the words that the indemnity related to damage “from any cause whatsoever” also suggested that it would include a “cause” outside the theatre or outside the actual surgical procedure.

The judge pointed out that the indemnity was worded in very wide terms. True, there was no express reference to negligence in the clause. In the absence of any limitation to the wording, it would seem clear that it has to be read to include the negligence of the clinic and its employees. Referring to an earlier case decided by the South African Appeal Court in which similar wording had been used, *Snyders J* held that the clause should be given its ordinary meaning, which leads to the conclusion that the words are wide enough to embrace the negligence and gross negligence of the clinic and its employees. (The earlier case did not involve a hospital, though.) Moreover, “no suggestion has been made in this case that the current facts should not be regarded to indicate an agreement between two parties with full freedom to enter into the agreement under consideration. I am therefore unable to conclude that the current agreement is against public policy.”

The patient appealed against the ruling, and a full bench (three judges) of the same division of the High Court upheld the appeal in March 2000 (its decision is not reported). The court of appeal analysed the “consent to operation” form and came to the conclusion that the correct interpretation of its wording is that it covered only incidents “arising out of or related to the administration of the anaesthetic or the operation”.

When the appeal was heard the patient’s counsel also argued that such a disclaimer was null and void because it was contrary to public policy, but the court of appeal in view of its interpretation of the document ruled that it was unnecessary to deal with the issue of public policy.

The case makes it abundantly clear that the last word on hospital or professional disclaimers has not been spoken.

What is particularly interesting about the *Burger* case is that the court of appeal has not ruled that such a disclaimer of liability by a hospital is null and void as such. The appeal court’s decision goes no further than a disagreement with the trial court on the ambit of the wording of the clause in question.

This means that the trial judge’s ruling still provides authority for the proposition that such a disclaimer is legally enforceable to the extent that it is in fact applicable to the act(s) or omission(s) in question.

In *Afrox Healthcare Bpk v Strydom* 2002 (5) SA 21 (SCA) an aggrieved patient who alleged that his treatment by hospital staff had been negligent, contended *inter alia* that the indemnity clause signed by him was *contra bonos mores* or, alternatively, that the principle of *bona fides* demanded that the existence of such clause and the implication thereof should have been

pointed out to him pertinently by the staff, particularly in view of the fact that the hospital was “providing essential health services, which services are a basic right the [patient] is entitled to”. Mavundla AJ upheld these contentions and found in the favour of the patient.

The Supreme Court of Appeal set aside the judgment of the trial judge and came to the conclusion that the **indemnity clause (or disclaimer) was indeed legally enforceable**. The court came to the conclusion that inequality in the bargaining power of the parties to a contract does not in itself justify the conclusion that a contractual clause which is to the advantage of the “stronger” party, necessarily is against the public interest. In the present case there had been no evidence that the patient, at the time of entering into the contract, was in fact in a weaker position than the hospital. 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 further held that the indemnity clause did not offend against the values contained in section 27(1)(a) of the Constitution by which the right to access to health-care services are guaranteed. There is nothing to prevent a private hospital from insisting on being remunerated for medical services or from imposing legally enforceable conditions for providing such services. The argument that the indemnity clause would promote negligence on the part of hospital staff does not hold water. Nursing personnel are at all times bound by their professional code and the statutory authority regulating their professional control body.

Moreover, the Appeal Court stated, the Constitution did not nullify the old established principle of *stare decisis* (whereby decisions of a higher court must be followed by courts with more limited powers, unless and until overturned by the higher court).

The Appeal Court also rejected the argument that the indemnity clause was contrary to the principle of *bona fides* (good faith). An abstract notion of that kind is not an independent or “free-floating” basis for setting aside a contractual clause; it is not an independent legal principle.

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

In certain overseas jurisdictions waivers of liability in respect of medical mishaps by doctors or health-care providers have been received with hostility by the courts. In England it is accepted that these clauses in a hospital contract or a contract with a doctor will not be enforceable where the patient was killed or injured, in the light of the provisions of the Unfair Contract Terms Act 1977. That Act provides that a person cannot by reference to any contract term or to a notice given to persons generally or to a particular person exclude or restrict his liability for death or personal injury resulting

from negligence. It is further provided that where a contract term or notice purports to exclude or restrict liability for negligence, a person's agreement to or awareness of it is not in itself to be taken as indicating his voluntary acceptance of risk.

In Germany the consensus of legal opinion is that the contract between doctor and patient is not without limitations. In principle the parties are free to shape the agreement to suit their needs, but agreements that offend against the *boni mores* (public policy) or against a law are prohibited. Grossly unethical conduct on the part of a doctor or conduct clearly in conflict with the medical professional code of conduct is against public policy and therefore unenforceable. Limitation of liability without a valid reason is against public policy (Deutsch *E Arztrecht und Arzneimittelrecht* 2 ed (1991) 38).

Deutsch cites two German cases. In the first case a patient who suffered from headaches was subjected to a carotid angiogram (an X-ray photograph of the main artery of the neck). This resulted in considerable neurological disturbances. In deciding whether liability arose because of failure on the part of the doctors to adequately inform the patient, a factor was that in terms of the conditions of admission of the hospital, the liability of the treating doctor was limited to intentional malfeasance and gross negligence. The court held that this provision was contrary to public policy because it is unreasonable to exclude the right of a patient to sue for damages where the patient, in a situation of illness or an accident, has no other choice than to subject himself to medical treatment. In the second case a patient brought a claim for damages against a hospital authority. The patient suffered yet another mishap. He was to be operated upon in the same hospital in the afternoon. That morning he signed a statement to the effect that he withdrew his claim against the hospital. The court regarded reliance of the hospital authority on this statement as an impermissible exercise of rights, because the patient was required to sign this statement in the context of the proposed operation.

As is the case in Germany, in the USA releases of liability or waivers of the right to sue for medical negligence signed at the time of treatment are generally regarded as unenforceable in view of being contrary to public policy, even if they are correctly worded. The seminal case is that of *Tunkl v Regents of the University of California* 383 P 2d 441 (Cal 1963): T sued a university which operated a hospital as a non-profit charitable institution, for injuries alleged to have resulted from the negligence of two doctors in the employ of the hospital. Upon admission as a patient T signed a form containing *inter alia* a release from liability for negligence. A section of the Californian Civil Code declared exemption contracts in respect of fraudulent, wilful conduct or negligence "against the policy of the law". The Californian courts ruled that the exculpatory provision may stand only if it does not involve "the public interest". The *Tunkl* court pointed out that a hospital is economically in a stronger bargaining position than the would-be patient. The patient is in no position to reject the preferred agreement, to bargain with the hospital, or in lieu of agreement, to find another hospital. "The admission room of a hospital contains no bargaining table where, as in a private business transaction, the parties can debate the terms of their contract," the judge said. In the event the clause was found to be against the

public interest and unenforceable. Courts of other states have come to the same conclusion (see Curran et al *Health care: law and ethics* (5ed 1998) 175, 444).

ACTIVITIES

1. Discuss the principles relating to the standard of care required of medical practitioners, with reference also to the proof of medical negligence and the burden of such proof.
2. What is understood by “vicarious liability” in the law of delict, and what is the practical significance of this concept? Discuss.
3. A patient is admitted to a hospital severely ill, and has to undergo surgery. Upon admission to the hospital she is required to sign a lengthy form setting out the standard conditions of admission. One of the clauses of the form is to the effect that the hospital will not be liable legally for any harm sustained by the patient in the course of her hospitalisation, even if such harm is attributable to the negligence of the hospital staff. She is in fact so harmed, and sues the hospital for damages. She contends that upon admission she did not read the document. The hospital pleads the disclaimer clause as one of its defences. What are its chances to succeed with this defence? Discuss.

FEEDBACK

1. There are well-established criteria in our law regarding the standard of care required from medical personnel. It is not to be assessed in the light of how the best qualified, most competent practitioner would have acted. Only reasonable care is required. One of the important practical issues regarding the proof of negligence is whether an adverse inference may be drawn merely from the fact that something went seriously wrong, resulting in harm to the patient (*res ipsa loquitur*). So far judicial pronouncements in South Africa have not favoured application of this doctrine.
2. Vicarious liability is a highly important principle of our law of delict. It refers to the liability of a person or organisation for acts perpetrated by another person, usually the employee of the former. The relationship of employment, and in particular assessing the scope of employment, has received attention in a number of South African cases. The doctrine of vicarious liability enables persons harmed by the acts or omissions of employees to sue the employer, who ordinarily has “the deepest pocket”.
3. The validity of disclaimers of this nature has been the subject of a number of court rulings in South Africa, but commanded the attention of our courts with regard to harm suffered in the hospital context only in recent years. In principle these clauses are regarded as valid, although there are indications that the courts will interpret them narrowly. The fact that a signatory of a hospital admission form has not read the document will ordinarily not be of any help to the signatory in pressing a claim for damages.