The involuntary isolation of patients with XDR-TB: Is the term 'health service' in section 7 of Act 61 of 2003 interpreted too broadly?

Minister of Health, Western Cape v Goliath and Others
2009 (2) SA 248 (C)

Introduction

The increase in the incidence of multi-drug-resistant tuberculosis (MDR-TB) and extensively drug-resistant tuberculosis (XDR-TB) in South Africa presents novel ethical and legal questions to health care workers and public health officials involved the combat against the spread of these diseases. The care and treatment of MDR-TB and XDR-TB patients involve a balancing of competing individual and societal rights, namely, the rights of MDR-TB and XDR-TB patients to their physical integrity, human dignity and freedom of movement (among others) are posited against the duty of the state to protect the general South African public from becoming infected with these diseases.

Tuberculosis (TB) is an airborne disease caused by the bacterium mycobacterium tuberculosis. In 2007 (the latest data available) the TB incidence[1] in the country was estimated at 460 600 cases - just under half a million.[2] Although 'simple' TB readily responds to treatment, the MDR-TB

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[1]There exist two measures of the occurrence of communicable diseases such as TB, and these measures are *prevalence* and *incidence*. The *prevalence* of TB refers to the proportion of persons in a specified population who are infected with TB at a specified point in time. The *incidence* of TB refers to the proportion of persons in a specified population who become newly infected with TB over a specified period of time (Nelson *et al Infectious disease epidemiology: Theory and practice* (2000) 97). The figure of 460 600 is considered to be a conservative estimate as many cases go unreported and untreated.

[2]WHO 'Online Tuberculosis Database' available at: http://apps.who.int/globalatlas/dataQuery/reportData.asp?rptType=2 (accessed 2009-09-30).

and XDR-TB are strains of the disease that are resistant to treatment. MDR-TB is a form of tuberculosis that is known to be resistant to rifampicin and isoniazid, the two most powerful anti-tuberculosis drugs available.[3] XDR-TB is a form of tuberculosis that is resistant to treatment with at least two of the most powerful first-line anti-tuberculosis drugs (rifampicin, isoniazid and fluoroquinolone) as well as to at least one of the three injectable drugs (capreomycin, kanamycin, and amikacin) used to treat the disease.[4]

In South Africa, the prevalence of HIV has provided the MDR-TB and XDR-TB strains of tuberculosis a niche in which to flourish. The compromised immune systems of persons living with HIV and AIDS leave them particularly vulnerable to infection if they are exposed to MDR-TB and XDR-TB.[5] The mortality rate of patients with MDR-TB, and more especially with XDR-TB, is extremely high because of the reduced number of treatment options available.[6] Moreover, the disease requires complex treatment regimens that carry high risks and have severe side-effects.[7]

In many liberal democracies, patients with MDR-TB and XDR-TB are subjected to public health control measures such as compulsory treatment, compulsory quarantine and compulsory isolation or detention.[8] These control measures are considered ethically and

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[3]Boggio *et al* 'Limitations on human rights: Are they justifiable to reduce the burden of TB in the era of MDR- and XDR-TB?' (2008) *Health and Human Rights* 1.

[4]*Ibid*; Holtz 'TB in South Africa: A revised definition' (2007) *Plos Medicine* e160.

[5]Perumal, Padayatchi and Stiefvater 'The whole is greater than the sum of the parts: Recognising missed opportunities for an optimal response to the rapidly maturing TB-HIV co-epidemic in South Africa' (2009) *BMJ Public Health* 243-246 at 243; Yew and Leung 'Management of multidrug-resistant tuberculosis: Update 2007' (2008) *Respirology* 13 at 21-46; and Singh, Upshur and Padayatchi 'XDR-TB in South Africa: No time for denial or complacency' (2007) *Plos Medicine* 19-20 at 19.

[6]XDR-TB has a survival rate of 30-50%; see Centers for Disease Control 'Extensively Drug-Resistant Tuberculosis (XDR TB)' available at: http://www.cdc.gov/tb/pubs/tbfactsheets/xdrtb.htm (accessed 2009-09-30); Bateman 'XDR TB: Humane confinement "a priority"' (2007) *SAMJ* 126-127 at 126.

[7]See London 'Confinement in the management of drug-resistant TB: The unsavoury prospect of balancing individual human rights and the public good' (2008) *SAJBL* 11.

[8]This refers to such countries as Canada, the USA, the UK, Australia and certain countries in Western Europe. It is important to distinguish between 'quarantine' and 'isolation': quarantine is the compulsory physical separation (which includes restriction of movement) of healthy persons who have been potentially exposed to a contagious disease, or, to efforts to segregate these persons within specified geographic areas, while 'isolation' is the separation and confinement of individuals with signs, symptoms, or laboratory tested evidence of infection in order to prevent them from transmitting the disease to others (see Viens *et al* 'Your liberty or your life: Reciprocity in the use of restrictive measures in contexts of contagion' (2009) *Bioethical Inquiry* 208, fn 1, and Swendiman and Elsea

legally justified in order to protect a greater public good, that is, the health of the wider population. In these countries limitations upon the individual's physical integrity, human dignity, privacy and freedom of movement are considered justified to advance the common good of the community.

In South Africa, the legality or justifiability of the compulsory admission to hospital and the continued isolation of patients with XDR-TB was considered by the Cape High Court in the case of *Minister of Health, Western Cape v Goliath*.[9]

Facts

The case comes in the wake of numerous media reports detailing escapes and attempted escapes of XDR-TB patients from isolation in treatment centres around the country.[10] The case concerns the compulsory admission to and continued isolation of the respondents - who were XDR-TB patients - at the Brooklyn Chest Hospital in Cape Town. The application followed upon the granting to the Provincial MEC for Health of a *rule nisi*, requiring that the respondents show cause on the return day why an order should not be granted which:[11]

- compels their admission to the Brooklyn Chest Hospital;
- authorises the South African Police Service to ensure that they are admitted to the Brooklyn Chest Hospital and to remain there until they have fulfilled the criteria for negative sputum culture conversion for XDR-TB for a period of three consecutive months; and
- compels their adherence to the rules of behaviour for XDR-TB patients at the Brooklyn Chest Hospital.

The respondents, in turn, served answering affidavits together with a counter-application seeking an order to declare their detention to be inconsistent with their right to physical integrity (referred to as 'personal freedom' in the case) as enshrined in section 12 of the Constitution of the Republic of South Africa, 1996. They also sought further declaratory relief and a structural interdict.[12]

'CRS Report RL33201, Federal and State Quarantine and Isolation Authority'.

[9]2009 (2) SA 248 (C).

[10]See, eg, 'South African TB patients rampage' available at: http://news.yahoo.com/s/ap/20080627/ap_on_re_af/south_africa_tb&printer+1;_ytl+ (accessed 2009-09-30); and Bateman (n 6) 127.

[11]*Goliath* para 2.

[12]The subject matter of the declaratory relief and structural interdict may be found in paras 31-33. As the present discussion is limited to the Court's interpretation of the term 'health

The respondents argued that the provisions of section 7 of the National Health Act 61 of 2003 do not apply to their situation. They contended that they were being arrested and detained against their will, and that the issue in contention, therefore, is not the provision of a 'health service' without the user's informed consent, but rather the arrest and detention of the user, neither of which is provided for in the National Health Act. Such matters are to be dealt with in the 'Regulations Relating to Communicable Diseases' to be adopted in terms of section 90(1)(j) of the Act.[13]

The respondents further argued that although the 'Regulations Relating to Communicable Diseases and the Notification of Notifiable Medical Conditions'[14] published in terms of sections 32, 33 and 34 of the previous Health Act do indeed provide for the compulsory medical examination, isolation, hospitalisation or treatment of persons suffering from a communicable disease, these regulations have become 'practically unworkable' as large sections of the previous Act had been repealed.[15] Therefore, according to the respondents, there exists no 'law of general application' as required by section 36 of the Constitution to allow for the limitation of their constitutional rights.

Judgment

The Court held (per Griesel J) that the isolation of patients with infectious diseases was universally recognised in open and democratic societies as justifiable to protect and preserve the health of citizens.[16] While conceding that the respondents' argument regarding the lack of an existing 'law of general application' to authorise their isolation and detention was not 'without some merit', the Court found that the term 'health services' as used in section 7 of the National Health Act and as defined in section 1 of that Act, is 'wide enough to encompass the

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service', the structural interdict and declaratory relief sought are not discussed here.

[13] *Goliath* para 24.

[14] See 'Regulations Relating to Communicable Diseases and the Notification of Notifiable Conditions' No R2438 in *GG* of 1987-10-30, promulgated in terms of the Health Act 63 of 1977. The compulsory medical examination, hospitalisation, isolation and treatment of persons who suffer from a communicable disease (which includes TB) are provided for by these Regulations.

[15] *Goliath* para 25.

[16] *Id* para 19. As the present discussion concerns itself solely with the Court's interpretation of the term 'health service' in s 7 of the National Health Act, no attention is given to the Court's discussion of the justifiability of the respondents' isolation in terms of s 36 of the Constitution.

involuntary isolation of patients with infectious diseases' at a health care facility.[17] Section 7 of the Act therefore constitutes a 'law of general application' limiting the respondents' rights. The Court nevertheless made the following cautionary remark:[18]

> Having said that, it is undoubtedly preferable that the full statutory and regulatory framework be put into place and implemented as soon as practically possible by promulgating the draft regulations that have been published for comment as long ago as January this year.

Discussion

Section 7 of the National Health Act authorises the provision under certain circumstances of a 'health service' without the user's informed consent. It reads:

> 7(1) Subject to section 8, a health service may not be provided to a user without the user's informed consent, unless -
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> (a) ...
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> (b) ...
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> (c) the provision of a health service without informed consent is authorised in terms of any law or a court order;
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> (d) failure to treat the user, or group of people which includes the user, will result in a serious risk to public health; or
>
> (e) ...
>
> (2) A health care provider must take all reasonable steps to obtain the user's informed consent.

As pointed out above, it is only if 'health service' in section 7 could be interpreted by the Court to include the involuntary isolation of XDR-TB patients that it might be used (as a law of general application) to authorise the involuntary isolation of XDR-TB patients at Brooklyn Chest Hospital.

The applicants' reliance upon the National Health Act is one of the most peculiar aspects of the case. The National Health Act was adopted in 2003,[19] but substantial sections of the Act are yet to enter into operation as they await the adoption of the accompanying regulations that will give effect to the broad provisions of the Act.[20]

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[17] *Id* para 27.

[18] *Id* para 28.

[19] The Act came into operation in May 2005, with certain exceptions. See Proc R19 in *GG* 27503 of 2005-04-18.

[20] These include, for example, 'Use of DNA, RNA, cultured cells, stem cells, blastomeres, polar bodies, embryos, embryonic tissue and small tissue biopsies for diag-

The compulsory isolation of patients who pose a serious threat to public health is covered in the as yet non-operative accompanying regulations in terms of section 90 of the Act.[21] It is submitted that, until these regulations come into effect, the regulations made in terms of the previous Health Act of 1977 remain in force as the relevant sections of the previous Act have not yet been repealed. There is no reason why these regulations should be 'unworkable' as alleged by the respondents, as the sections of the Health Act in terms of which they were promulgated remain in force.[22]

However, instead of relying on the regulations promulgated in terms of the previous Act, the applicants relied on section 7 of the 'new' National Health Act quoted above. The term 'health services' is defined in section 1 of the Act as -

(a) health care services, including reproductive health care and emergency medical treatment, contemplated in section 27[23] of the Constitution;
(b) basic nutrition and basic health care services contemplated in section 28(1)(c) of the Constitution;
(c) medical treatment contemplated in section 35(2)(e)[24] of the Constitution; and
(d) municipal health services[25] ...

It is submitted that the Court erred in finding that the term 'health services' as used in section 7 authorises the involuntary isolation of patients with XDR-TB. It is unclear how the Court arrived at this conclusion, as it states that the concept is 'wide enough ... to encompass the involuntary isolation' of the respondent patients,[26] without providing any argument as to how this decision was reached.

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nostic testing, health research and therapeutics: Draft' (*GG* 29526); 'Artificial fertilisation and related matters: Draft' (*GG* 29527); and 'Regulations relating to research on human subjects: Draft' (*GG* 29637).

[21]Draft 'Regulations Regarding Communicable Diseases' (*GG* 30681 of 2008-01-25).

[22]Sections 32-34 of Act 63 of 1977.

[23]The term 'health care services' is not defined in s 27 the Constitution, but it is often argued that its scope must be broad, so as to include not only diseased states, but also healthy states (see Carstens and Pearmain *Foundational principles of South African medical law* (2007) 39).

[24]Section 35(2)(e) of the Constitution contains the right of detained persons to 'adequate medical treatment'.

[25]The term 'municipal health services' includes the 'surveillance and prevention of communicable diseases' (s 1).

[26]*Goliath* para 27.

Firstly, even if one follows an approach to legislative interpretation that assigns the broadest possible meaning to 'health services', it is doubtful whether the term, as used in section 7, could ever include the involuntary isolation or detention of XDR-TB patients. When seen in the context of section 7 and in the context of the Act as a whole, the concept of 'health services' is limited to different forms of medical *treatment* which, under certain circumstances, may be provided without the user's informed consent. Section 7 could therefore readily be interpreted to include involuntary medical *treatment* authorised by a court order,[27] but there exists a vast difference in meaning between involuntary treatment and involuntary isolation and detention. Neither does treatment, of necessity, imply isolation. Patients with XDR-TB do not have to be detained and isolated to be treated, and scientific evidence indicates that these patients may sometimes be managed effectively on an out-patient basis.[28] Moreover, the phrasing of section 7(1)(d) makes it clear that we are dealing here with involuntary *treatment*, and not isolation: 'failure to *treat* the user, or group of people which includes the user, will result in a serious risk to public health'. In *Fourie v Minister of Home Affairs*,[29] Cameron JA observed that the Court may assign 'a broad meaning to a word whose purport was not certain' but could not do this if it would 'change the word'.[30] An interpretation of the term 'health services' which includes 'involuntary isolation' would indeed 'change the word'.

Secondly, in terms of section 39(2) of the Constitution, when interpreting any legislation, a court must 'promote the spirit, purport and objects of the Bill of Rights'. In other words, it is presumed that the legislature intended to further the values underlying the Bill of Rights by passing legislation which is in accordance with the Bill of Rights.[31] Legislation must therefore be interpreted so that it conforms

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[27]For example, a court order authorising a blood transfusion on a minor Jehovah's Witness.

[28]London writes as follows: '... DOTS coupled with strong community engagement, training of community health workers and careful organisation has produced impressive outcomes. Lastly, use of confinement will in all likelihood deter some patients from seeking health care, thereby exacerbating an existing epidemic. Using confinement to achieve better treatment outcomes therefore must be of questionable validity' (London (n 7) 15 (footnotes omitted).

[29]2005 3 BCLR 241 (SCA).

[30]*Id* para 31.

[31]Currie and de Waal *The Bill of Rights handbook* (2005) 64-65. This is known as 'reading down'. See *Bernstein v Bester* 1996 2 SA 751 (CC) and *Harksen v Lane* 1998 1 SA 300 (CC). In this regard, see Le Roux 'The Law Reform Commission's proposed Interpretation of

to the Bill of Rights.[32] The Cape High Court, by interpreting section 7 of the National Health Act so 'widely' as to allow the inclusion of the involuntary isolation of the respondents, did in fact (at least potentially)[33] sanction the infringement of their section 12(2) rights, and for this reason it is an interpretation which does not 'promote the spirit, purport and object' of the Bill of Rights and which is therefore in conflict with the interpretive imperative of section 39.

Finally, the Court's broad interpretation of 'health services' in section 7 flies in the face of a well-used presumption in statutory interpretation: that 'a strict construction [...] be placed upon statutory provisions which interfere with elementary rights'[34] and that if 'the legislature's intention be to encroach on existing rights of persons it is expected that it will manifest it plainly, if not in express words, at least by clear implication and beyond reasonable doubt'.[35] As part of a section which 'interferes with elementary rights' (by providing a list of exceptions to the consent to treatment requirement), the term 'health services' in section 7 should, according to this interpretive presumption, be given a 'strict construction' that closely adheres to its 'plain' meaning. An interpretation of 'health services' which sanctions the involuntary isolation of the respondents is too broad a construction, and it is too elaborate and far removed from the term's ordinary meaning to be in keeping with this presumption.

Conclusion

The justification of the practice of compulsory isolation of an unwilling patient with a highly infectious and life-threatening disease will always be controversial because it represents an infringement of that patient's right to physical integrity, freedom of movement and dignity. However, because such involuntary isolation protects important societal interests, it is a necessary last resort.

The Cape High Court's finding that section 7 of the National Health Act authorises the involuntary isolation of XDR-TB patients might have

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Legislation Bill: Critical comments' (2007) 22 *SAPR/PL* 523-524 at 520.

[32] Olivier JA sets out the procedure for this method of statutory interpretation in *Govender v Minister of Safety and Security* 2001 4 SA 273 (SCA) at para 11.

[33] 'Potentially' because the second leg of the s 36 limitation analysis has not yet been undertaken.

[34] *Dadoo Ltd v Krugersdorp Municipal Council* 1920 AD 530 at 552; see de Ville *Statutory interpretation* (2000) 195.

[35] *Mhlongo v MacDonald* 1940 AD 299 at 310.

temporarily solved a pressing public health problem (the respondents' absconding and thereby placing others at risk of infection with XDR-TB), but it has failed to provide a clear precedent that could end the uncertainty regarding the legality of involuntary isolation of XDR-TB patients.

At the heart of the problem lies the failure of the Department of Health to adopt workable regulations[36] that give effect to the rights of both drug resistant tuberculosis patients and the rights of the general public. More than eighteen months have passed since the draft 'Regulations Regarding Communicable Diseases' were published in the *Government Gazette*. The lack of political will to see through the promulgation of these regulations is resonant of the inadequacy of the Department's response to the HIV and AIDS epidemic in the previous decade.

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[36]Of course, the existing draft Regulations are far from ideal. See Van Wyk 'Tuberculosis and the limitation of rights in South Africa' (2009) *J of Contemporary Roman-Dutch L* 92-112 for her analysis and criticism of the draft Regulations.