

## Chapter 4

### Contractual Formalities in the Doctor/Hospital- Patient Relationship

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#### 4.1 Introduction

From what was stated in Chapters two and three the relationship between the doctor/hospital and patient, besides its general nature, is also contractual in nature. For that reason it is necessary to establish therefore, the manner and grounds upon which such contract is formed. It was stated in Chapter Three that although the nature of the contractual relationship between the medical practitioner/hospital and the patient has been described differently, varying from a contract of mandate, to a contract of service etc, unanimity exists amongst the legal writers universally, that the contractual relationship is a consensual one, the medical practitioner/hospital being a free agent or independent contractor who, when committing himself/herself/itself in treating the patient, creates a position of trust with the patient, wherein the practitioner/hospital undertakes to exercise reasonable care and skill.

In South African law, consideration is not an essential requirement for the existence of a contract, as it is in English law. The intention of the parties is therefore of paramount importance.<sup>1</sup> Both parties must have the requisite intention to create a legal relationship and obligation between the two of them. This is commonly known in legal parlance as *consensus ad idem*.<sup>2</sup> The fore stated is however, also subject to a further requirement, namely, the parties must have the necessary contractual capacity at the time, when the intention to conclude the agreement is formed.<sup>3</sup> Save for the so-called 'emergency' situations, a clear distinction is drawn between the capability, alternatively incapability and the exceptions between adult patients, juvenile patients and mentally ill patients.<sup>4</sup> There are clearly recognised occasions when especially juvenile patients and mentally ill patients may validly represent themselves, alternatively, be represented by someone else who may validly enter into agreements on their behalf.<sup>5</sup> A further requirement in the formation of the contractual relationship between the doctor/hospital and the patient is that the parties agree that one or both of the parties to the contract must perform something. The agreement for

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<sup>1</sup> In *Conradie v Roussouw* 1919 AD 279 the Appellant Division unanimously rejected the idea that the English doctrine of consideration forms part of South African law. De Villiers, AJA, concluded at p320 that "According to our law, if two or more persons, of sound mind and capable of contracting enter into a lawful agreement, a valid contract arises between them enforceable by action. The agreement may be for the benefit of one of them or both (Grotius 3.6.2). The promise must have been made with the intention that it should be accepted (Grotius 3.1.48); according to Voet the agreement must have been entered into serio ac deliberato animo. And this is what is meant by saying that the only element that our law requires for a valid contract is consensus, naturally within proper limits - it should be in or de re lucia ac honesta." See Christie (2001) 213; De Wet and Van Wyk (1992) 73 for a discussion of the element 'intention' as a requirement for the formation of a contract in general. Similarly, when a doctor/hospital enters into an agreement whereby the patient is to be treated and/or operated on there must be an intention to contract. See in this regard the writings of Van Oosten (1996) 54; Strauss and Strydom (1967) 105; Strauss (1991) 3; Claassen and Verschoor (1992) 115; Carstens and Pearmain (2007) 313-314.

<sup>2</sup> Christie (2006) 22; De Wet and Van Wyk (1992) 23-24; Lubbe and Murray (1988) 28; Van Oosten (1996) 54; Strauss and Strydom (1967) 105; Strauss (1991) 3; Claassen and Verschoor (1992) 115; Carstens and Pearmain (2007) 313-314.

<sup>3</sup> For the law regarding the contractual capacity in general see Christie (2006) 227ff; Lubbe and Murray (1988) 20; for the requirement of capacity in a medical sense in which the patient is required to have the necessary legal capacity to consent. In this regard he/she must be legally capable of consenting. See Van Oosten (1996) 65ff; Strauss and Strydom (1967) 119ff; Strauss (1991) 4ff; See also Carstens and Pearmain (2007) 248, 899-902 regarding the legal capacity of mentally ill patients; 898ff the legal capacity of adults.

<sup>4</sup> For a very comprehensive discussion on the legal capacity of various categories of patients see Carstens and Pearmain 898ff. See also Van Oosten (1996) 68ff; Strauss (1991) 4ff.

<sup>5</sup> In so far as youths are concerned they are usually represented by their parents, guardians or wards. Gordon et al (1953) 79; Strauss and Strydom (1967) 188; Strauss (1991) 6-7; Van Oosten *Encyclopaedia* (1996) 66. The *Children's Act* 38 of 2005 especially Section 39(4) does *inter alia* provide assistance to youths when they may enter into agreements themselves. The *Mental Health Care Act* 17 of 2002 also provides assistance for mentally ill patients who are institutionalized. For a full discussion on the writings of the *Children's Act* and the *Mental Health Care Act* see Carstens and Pearmain (2007) 899ff.



performance is one of the obligations which flow from the agreement.<sup>6</sup> For that reason the agreement concluded between the medical practitioner and the patient, or where there is a hospital involved, between the representative of the hospital and the patient, must be one for performance from which, a legal obligation arises for the medical practitioner or hospital. Once again a legal obligation cannot arise unless there is a valid agreement contemplated between the parties concerned. It has been stated by our legal writers, and held by our courts before, that duress or undue influence to bring about an agreement, negatively impacts on the validity of such agreement.<sup>7</sup> The agreement for performance between the doctor/hospital and the patient is said to entail that the doctor/hospital is expected to perform only that which he/she/it has undertaken to do unless, of course, the doctor/hospital expressly guaranteed some results.<sup>8</sup> The formation of a contract in South Africa, as previously indicated, is dependent on a number of factors which have been considered hereinbefore. A further requirement for a valid agreement between the doctor/hospital and the patient is that the agreement between them must not be against public policy or against good morals. Contracts that are contrary to public policy are generally unenforceable.<sup>9</sup> Any agreement entered into between the medical

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<sup>6</sup> Joubert et al *LAWSA* Volume 4 Part 1 (1994) par 125 with reference to the agreement for performance suggest that "*conscious accord can never manifest itself unless the parties intend to create between them an obligation (or obligations) with a specific content which include inter alia 'the consent of the obligations, that is to the performances to be rendered' must be clear.*" See also Christie (2006) 403; Lubbe and Murray (1988) 1ff. For the agreement for performance in the medical setting see Van Oosten *Encyclopaedia* (1996) 55; McQuiod-Mason and Strauss (1983) 144; Strauss and Strydom (1967) 106; Claassen and Verschoor (1992) 115-116; Dada and McQuiod-Mason (2001) 5. There is great unanimity amongst the legal writers that the agreement for performance which creates an obligation entails nothing more than to treat the patient with professional care and skill.

<sup>7</sup> For a general discussion on the effect of duress and undue influence on an agreement entered into see Christie (2006) 301ff; Lubbe and Murray (1988) 356ff, 374ff. For the *locus classicus* on the effect of duress on a contract entered into see *Broodryk v Smuts* No 1942 TPD 47 53; *Arends v Astra Furnishers (Pty) Ltd* 1974 (1) SA 298 (C) 306(A). For the leading authority involving an agreement entered into between a medical practitioner and patient, an elderly farmer upon whom the doctor exercised an undue influence see *Preller v Jordaan* (1956) 1 (SA) 483(A).

<sup>8</sup> See in this regard Van Oosten *Encyclopaedia* (1996) 55 "*The doctor undertakes no more than to treat or operate upon the patient with the amount of competence, care and skill which may be expected from a medical practitioner in the particular branch of the profession.*" See also McQuiod-Mason and Strauss *LAWSA* Volume 17 (1983) 144; Strauss and Strydom (1967) 106; Claassen and Verschoor (1992) 115-116; Dada and McQuiod-Mason (2001) 5. It does not however, in the absence of an express or implied warranty to that effect, include a guarantee that the patient will be cured or that the intervention will be a success. Van Oosten *Encyclopaedia* (1996) 55; Strauss and Strydom (1991) 329. In a number of cases our courts have held that by undertaking a case, a doctor does not guarantee that the patient will be cured of his disease (cf. the judge's remarks in *Buls and Another v Tsatsarolakis* 1976 (2) SA 891 (T) at 893; *Behrmann and Another v Klugman* 1988 (4) SA 6 (W); *Chalk v Fraser* (1995) WLD, unreported, discussed by Strauss 1995 (4) SAPM 1 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.*"

<sup>9</sup> See Christie (2006) 343ff; Lubbe and Murray (1988) 236ff. For case law see *Administratrix Natal v Edouard* 1990

practitioner/hospital and the patient which is against public policy or against good morals, negatively impacts on the validity of such agreements.<sup>10</sup> Although many cases involving contracts of general application have been decided by the South African courts over decades, the courts have not been invited to pronounce on the validity of medical contracts based on public policy in many cases. In the case of *Friedman v Glicksman*,<sup>11</sup> the court held that an agreement between a pregnant woman and a doctor, that he would advise her whether there was a greater risk than normal that she might have a potentially abnormal or disabled child, so that she might make an informed decision on whether or not to terminate the pregnancy is not *contra bonos mores* but sensible, moral and in accordance with modern medical practice. A case in point is that of *Afrox Healthcare Limited v Strydom*.<sup>12</sup> The facts and a full discussion of the case will be dealt with in a later chapter dealing with the validity of exclusionary clauses in hospital contracts, which forms the focal point of the investigative study conducted within this thesis. What is determined in the chapter is whether disclaimers (or exculpatory clauses) in hospital contracts have, contrary to the Supreme Court of Appeal's decision in the *Afrox case*, a right of existence in South Africa, suffice to say, in the *Afrox case* the court refused to allow a patient to escape the consequences of a disclaimer he had signed absolving the hospital from all liability and indemnifying it from any claim instituted by any person (including a dependant of the patient) for damages or loss of whatever nature (including consequential damages or special damages of any nature) flowing directly or indirectly from any injury (including fatal injury) suffered by, or damage caused to, the patient or any illness (including terminal illness) contracted by the patient, whatever the cause/causes, except only with the exclusion of intentional omission by the hospital, its employees or agents. The respondent contended *inter alia* that the relevant clause was contrary to the public interest. The Supreme Court of Appeal refused to accept the respondent's argument and ruled that such a clause is not against public policy. The judgement has and continues to receive much criticism and quite desirably so. It will be argued in the latter chapter that such disclaimers (or exclusionary clauses) in hospital contracts have no right of existence in South Africa, considering constitutional demands, foreign law and medico-legal considerations.

Generally, as was previously stated, the agreement between the doctor/hospital and patient

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(3) SA 581 (4); *Ryland v Edros* 1997 (2) SA 690 (C); *Sasfin (Pty) Ltd v Beukes* 1989 (1) SA 1 (AD).

<sup>10</sup> See the general comments by the Supreme Court of Appeal although not adopted in *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 (SCA).

<sup>11</sup> 1996 (1) SA 1134 (W).

<sup>12</sup> 2002 (6) SA 21 (SCA).

requires no legal formalities to bring about a valid contract. Where the agreement has not been reduced to writing and uncertainty prevails as to whether the parties have entered into an agreement *Christie*<sup>13</sup> suggests that the most common and normally helpful technique for ascertaining whether there has been agreement is to look for an offer and acceptance of that offer. This can be done by ascertaining whether some act manifesting assent and willingness to be bound by the terms of the contract is present.

From previous discourse it was ascertained that a contractual relationship between the doctor/hospital and patient can never come into being without consensual agreement being reached between the parties concerned.<sup>14</sup> Where there are terms created in the agreement, they must be understood when agreed to.

This is especially relevant and applicable in instances where more serious operations are undertaken or the medical practitioner engages in unusual treatment. In that event, it has become customary that the agreement is reduced to writing where a patient is admitted to a hospital. The patient then is required to sign an admission form which serves as an agreement between the medical practitioner/hospital/ healthcare provider and the patient. The admission form should, therefore, contain as comprehensive detail regarding the nature of the operation and/or treatment as possible. The admission form, in turn, serves as an offer to the patient setting out the terms of the agreement.

The following circumstances, in general terms, make it impossible for a contracting party to accept an offer, namely, he or she is unable to accept, for example, a patient in an emergency situation or where the validity of a contract may be affected by mistake (error), misrepresentation, duress, the contract as a whole being against public policy.

As a general rule, the contract entered into between the doctor and patient takes the form of a tacit agreement which includes implied terms. This will be covered more fully in Chapter Five. Suffice to say that one of the implied terms is that the doctor, when concluding the agreement, undertakes to execute his duties with the utmost care in treating

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<sup>13</sup> *The Law of Contract* 4th Ed (2006) at 28.

<sup>14</sup> *Christie* (2006) at 28 refers to *Reid Bros (SA) Ltd v Fischer Bearings Co Ltd* 1943 AD 232 where the court stated at p241 that "a binding contract is as a rule constituted by the acceptance of an offer" and *Estate Breat v Peri Urban Areas Health Board* 1955 3 SA 523 (A) at 532 E where it was stated that: "*Consensus is normally evidenced by offer and acceptance. But a contract may be concluded without offer and acceptance other than pure fictions imported into the transaction for doctrinal reasons. Nor does every accepted offer constitute a contract.*"

and/or operating on the patient. The implied term to exercise due care and skill has its roots in the fiduciary relationship between the doctor/hospital and the patient in which the doctor/hospital is expected to exercise their professional skills with the utmost diligence with the patient's interests being placed first.

There are occasions however, when expressed terms are relied on when entering into a contractual relationship. This is particularly relevant in situations where the doctor has to adopt unusual procedures when treating the patient or the patient is hospitalised and he/she enters into an agreement with the hospital. In these instances the agreements will be reduced to writing with the expressed terms agreed to being included in the agreement. The terms will include *inter alia* the treatment to be given, the procedure to be followed etc.

Although the doctor/hospital and patient enjoy the utmost freedom to contract<sup>15</sup> and generally wide latitude is allowed in their selection of express terms,<sup>16</sup> which they purport to agree to, they are not without limits. They cannot, for example, agree to that which would be regarded as contrary to public policy.<sup>17</sup> Since constitutional values and principles now infuse public policy, the principle of freedom of contract, in the new constitutional

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<sup>15</sup> Freedom to contract and the sanctity of contract have been identified as principles that are fundamental to the law of contract in South Africa. This freedom has also hitherto been based on public policy. See *Standard Bank of SA Ltd v Wilkinson* 1993 (3) SA 822 (C) in which the court stated: "Which brings us to the third aspect that must be borne in mind, viz. that public policy favours the utmost freedom of contract and requires that commercial transactions should not be unduly trammelled by restrictions on that freedom (see *Sasfin* at 9E-F). As Innes CJ said in the *Law Union Rock* case, supra at 598, "Public policy demands in general full freedom of contract, the right of men freely to bind them in respect of all legitimate subject matters."

One is further reminded of the much-quoted aphorism of Jessel MR in *Printing and Numerical Registering Co v Sampson* (1875) LR Esq. 462 at 465: "If there is one thing which more than another public policy requires, it is that men of full age and competent understanding shall have the utmost liberty of contracting and that their contracts, when entered into freely and voluntarily, shall be held sacred and shall be enforced by courts of justice." (See also *Wells v South African Alumenite Company* 1927 AD 69 at p73) In *SA Sentrale Ko-op Graanmaatskappy Bpk v Shifren en and ere* 1964 (4) SA 760 (A) at 767A Steyn CJ emphasized "die elementêre en grondliggende algemene beginsel dat kontrakte wat vryelik en in alle erns deur bevoegde partye aangegaan is, in die openbare belang afgedwing word." It is this freedom of contract and the voluntary acceptance by a surety of the burdens of surety ship that bring us to the conclusion that it is only when a surety ship agreement or some of its terms are clearly inimical to the interests of the community as a whole that it or they should be declared to be objectionable."

<sup>16</sup> See van Oosten *Encyclopaedia* (1996) 57.

<sup>17</sup> See Van Oosten *Encyclopaedia* (1996) 88; See also Strauss and Strydom (1967) 110, 324 "argue that where such an agreement of waiver is entered into by a doctor with his patient it ought to be regarded as null and void as being contrary to public policy." See also Strauss (1983) footnote 43 at 349. The author expresses the opinion "that the same consideration ought to apply in the case of hospitals in respect of personal injury to the patient. After all, it is the interest in his bodily inviolability (the *persoonlikheidsgoed*) that is at stake here and not merely his patrimonial interest." See further Claassen and Verschoor (1992) 102 ex seq.; See further Van Dokkum "Hospital Consent Forms" *Stell., LR* (1996) 255; See further Cronje-Retief (2000) 440 et seq.



order, must similarly be acknowledged and shaped in accordance with constitutional values and principles.<sup>18</sup> Even before the Constitution came into being, the limits of the freedom of contract were very much influenced by public policy.<sup>19</sup>

As was previously stated, in order for a contract to arise, there must be an intention to

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<sup>18</sup> Pearmain (2004) 527.

<sup>19</sup> In *Bank of Lisbon and South Africa Ltd v De Ormelas and Another* fn 45 supra Jansen JA stated: Apart from statutory innovations, there are in any event a number of well-recognised instances in our law contract where freedom of contract and the principle of *pacta servande sunt* and the ideal of certainty give way to other considerations. A few examples may be mentioned. A creditor has a right to specific performance but a Court may in the exercise of its discretion refuse to make such an order. The discretion is aimed at preventing an injustice - for cases do arise where justice demands that a plaintiff be denied his right to performance - and the basic principle thus is that the order which the Court makes should not produce an unjust result which will be the case, egg, if, in the particular circumstances, the order will operate unduly harshly on the defendant. Another principle is that the remedy of specific performance should always be granted or withheld in accordance with legal and public policy....' (Per Hefer JA in *Benson v SA Mutual Life Assurance Society* 1986 (1) SA 776 (A) at 783D-E). A restraint of trade is not per se invalid or unenforceable - but it is so if it offends against the public interest *Magna Alloys and Research (SA) (Pty) Ltd v Ellis* 1984 (4) SA 874 (A). In delivering the judgement of the Court, Rabie CJ points out: "Omdat opvatting oor wat in die openbare belang is, of wat die openbare belang vereis, nie altyd dieselfde is nie en van tyd tot tyd kan verander, kan daar oor geen numerus clausus wees van soorte ooreenkomste wat as strydig met die openbare belang beskou kan word nie. Dit sou dus volgens die beginsels van ons reg moontlik wees om te sê dat 'n ooreenkoms wat iemand se handelsvryheid inkort teen die openbare belang is indien die omstandighede van die betrokke geval sodanig is dat die Hof daarvan oortuig is dat die afdwing van die betrokke ooreenkoms die openbare belang sou skaad" and further "Die opvatting dat 'n persoon van 'n beperking wil afdwing nie die las dra om te bewys dat dit redelik inter partes is nie, bring nie mee dat oorwegings van die redelikheid of onredelikheid van 'n beperking nie van belang is of kan wees nie. (At 803H). Die belangrike vraag is dus nie of 'n ooreenkoms van so 'n aard is dat dit ab initio ongeldig is nie, maar of dit 'n ooreenkoms is wat die Hof, gesien die vereistes van die openbare belang, nie behoort af te dwing nie." (At 895 D-E). The Court may reduce a stipulated penalty to such an extent as it may consider equitable in the circumstances (Act 15 of 1962, S3 - reinstating the common law). Not only contracts against public interest or public policy are subject to control by the Court, but also justice (regsgevoel) of the community, as is the case in delict, where it is now recognised that there is no *numerus* those offending the boni mores. In this field reference must be made to the sense of *clausus* of actionable wrongs. But the influence of the doctrine of sanctity of contract and the maxim *pacta sunt servanda* have been so great that Sachs J in a recent Constitutional Court judgement of *Barkhuizen v Napier* 2007 (5) SA 323 (CC) Para 14 remarked that their usage "through judicial and text-book repetition come to appear axiomatic, indeed mesmeric, to many in the legal world." Ngcobo J at Para 15 delivering the majority judgement also remarked: "I do not understand the Supreme Court of Appeal as suggesting that the principle of contract *pacta sunt servanda* is a sacred cow that should trump all other considerations." The court goes on to state: All law, including the common law of contract, is now subject to constitutional control. The validity of all law depends on their consistency with the provisions of the Constitution and the values that underlie our Constitution. The application of the principle *pacta sunt servanda* is, therefore, subject to constitutional control." And further: "Public policy represents the legal convictions of the community; it represents those values that are held most dear by the society. Determining the content of public policy was once fraught with difficulties. That is no longer the case. Since the advent of our constitutional democracy, public policy is now deeply rooted in our Constitution and the values which underlie it. Indeed, the founding provisions of our Constitution make it plain: our constitutional democracy is founded on, among other values, the values of human dignity, the achievement of equality and the advancement of human rights and freedoms, and the rule of law." The court consequently lay down the following test: "What public policy is and whether a term in a contract is contrary to public policy must now be determined by reference to the values that underlie our constitutional democracy as given expression by the provisions of the Bill of Rights. Thus a term in a contract that is inimical to the values enshrined in our Constitution is contrary to public policy and is, therefore, unenforceable."

contract. The intention to contract, on the other hand, must be exercised freely and with knowledge of that which is agreed to. The patient, in particular, must be aware of what he/she agrees to. One of the material manifestations of the existence of consensus between the parties is that of consent. It has often been stated that the patient's effective consent is fundamental to medical treatment. In the new constitutional order every patient has a constitutional right to his/her bodily integrity and security. In the absence of consent, the doctor/hospital conduct, save in certain instances such as emergency, may well be viewed as a violation of a constitutional right. Consent takes various forms, including express or implied consent, and may be executed in oral or written form. Certain legislative provisions require that consent be reduced to writing. In practice it is especially in hospital admission forms that consent forms are incorporated. But, there is no legal requirement for consent to be in written form.

The role of informed consent in the formation and conclusion of a contract is of great importance in the practice of medicine.<sup>20</sup>

The rationale for the patient's informed decision-making opportunity is founded upon the principle that, in a medical context, the patient's consent is of paramount importance within the medical practitioner/hospital/healthcare provider and patient's contractual relationship. Besides creating and promoting a healthy relationship between the medical practitioner/hospital/other healthcare provider and the patient, at common law and in terms of the Constitution, the patient, as was stated earlier, has the right to integrity and security.

For consent, however, to be real, there has to be an exchange of information between the medical practitioner/hospital/healthcare provider and the patient. It is this imparting of appropriate information and the acquisition of knowledge of material risks of complications, as was previously stated which puts the patient in a position to make an informed decision. It is this exchange of information, in which the patient acquires knowledge and appreciation in order to put him in a position to make an informed decision, which is also known as informed consent.

A failure in making a decision based on the awareness of the circumstances may very well result in the patient raising a defence of misrepresentation, which is a fundamental and inherent conflict that arises within the law of contract in the context of health service

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<sup>20</sup> This causes Carstens and Pearmain (2007) 322 to remark that "*informed consent from a contractual point of view is important to ensure consensus and that the parties are bound by the terms of their agreement.*"



delivery.<sup>21</sup>

The South African writers and the courts have in more recent years of the history of medical jurisprudence; put a premium on the presence of informed consent.<sup>22</sup> The value in recognizing informed consent has a twofold purpose namely; it firstly enhances a proper and healthy relationship between the medical practitioner/hospital/other healthcare provider and the patient.<sup>23</sup> In this relationship, the medical practitioner/hospital/other healthcare provider no longer assumes a paternalistic role, in which, the patient has no say in the decision-making process regarding his/her own treatment. What has changed fundamentally as well is the shift in, especially, the doctor-patient paradigm, in which the patient now assumes an autonomous role in exercising his/her right to self-determination. In this regard,

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<sup>21</sup> Pearmain (2004) 520; Christie (2006) 320 observes that silence may amount to misrepresentation in some cases. This may according to Pearmain (2004) 522 where a party, not necessarily with dishonest motive, has done something which has had the effect of concealing facts which would otherwise been apparent to the other party. *Dibley v Furter* 1951 (4) SA 73(C); *Knight v Hemming* 1959 (1) SA (EC); where a party presents for signature a standard form contract without drawing attention to an unusually onerous clause, in circumstances where he must have known that the signatory would not read the contract and discover the clause *Kempston Hire (Pty) Ltd v Snyman* 1988 (4) SA 371 (SE). For the more recent constitutional court dictum of *Barkhuizen v Napier* 2007 (5) SA 323 (CC) the comments of Sachs J on the ill effects of standard form contracts Para 182.

<sup>22</sup> Christie (2006) 322 states that partners, and agents by the very nature of their relationship is put in a position of involuntary reliance on sharing of information. In this regard Christie hold the following view: "..... we require disclosure of material facts in insurance and other contracts not because they are contracts *uberrimae fidei* but because they are contracts in which a situation of involuntary reliance necessarily exists, and we came to attach the *uberrimae fides* label to them as a reminder that, in them, this situation always exists." Pearmain (2004) 423 hold the view that the patient is very much involuntarily reliant on the healthcare provider to disclose information. This fits the paradigm of duties of disclosure in the so-called fiduciary relationship.

<sup>23</sup> The relationship advocated is the one built on the so-called fiduciary relationship. See Pearmain (2004) 523ff. Although it is a concept that has not really developed in South Africa as much as in Canadian law nonetheless it is not a foreign concept. Litman "Self-referral and kickbacks: Fiduciary law and the regulation of Trafficking in Patients" 2004 *CMAJ* 170 (7) 1119 has the following comments to make: "Fiduciaries are 'obligatory altruists'. They must selflessly, although not without remuneration, attend to their patients interests with single-minded attention. In law, physicians are fiduciaries because they undertake to dedicate themselves to their patients, who have a reasonable expectation of such dedication, and patients rely on it implicitly. Factors which give rise to the fiduciary duty of physicians include the power and influence of physicians, the vulnerability and dependence of patients and the solemn pledge of physicians to act only in their patients' interests. Fiduciary duty mandates exemplary relational behaviours and unlike malpractice law, is not concerned with standard of care issues. As fiduciaries, physicians must discharge their responsibilities to patients with loyalty, honesty, candour and good faith, all the while avoiding conflict of interest. Material interests that compete with the interests of patients, including benefits of self-referrals and kickbacks, must be avoided for they give rise to a 'reasonable possibility of mischief' (footnotes omitted). Fiduciary law in South Africa with regard to health professionals in particular appears to be largely undeveloped compared to the Canadian situation. Given that, despite this, the Canadians still experience problems with flagrant disregard of these legally imposed duties, it is hardly surprising that there are problems of this nature in South Africa where the law on this subject is not developed. Given the approach of the South African courts to health care contracts, it is likely to remain so unless the Legislature steps in. It is Pearmain (2004) 525 who persuasively argues that it is unfortunate that the Supreme Court of Appeal in the *Afrox Healthcare v Strydom* case was unable to adopt these principles but continued to see the hospital as a supplier of goods and services.

the patient has a greater say in the decision-making process affecting his/her welfare. Secondly, the value in recognising informed consent has also proved to be essential for lawful medical interventions. For medical interventions, whether they take the form of treatment or experimental, to be lawful, informed consent is essential, in that, informed consent serves as a ground of justification to escape criminal and/or civil liability.

The doctrine of informed consent can only be effective provided certain requirements are met. The requirements include, consent must be recognised by law, that is, that which is consented to must not be *contra bonos mores* or against public interests; besides the consent being free and voluntary, consent must be given by someone capable of consenting; the consenting party must have had knowledge and been aware of the nature and extent of the harm or risk; the consenting party must have appreciated and understood the nature and extent of the harm or risk. The nature and scope of the information which must be discussed by the physician should now be assessed in context of legislative requirements.<sup>24</sup> For full appreciation and understanding to take place, the information given to the patient must be as comprehensive as possible, clear and unequivocal, before it can be said that the patient consented to the harm or assumed the risk. With regard to the patient consenting to the harm or assumed risk, although the South African legal writers recognise the doctrines of *volenti non fit iniuria* and informed consent they are not unlimited, in that individual autonomy is limited by considerations of individual and social responsibility. Public interests dictate that the prevailing legal convictions of the community aim to protect the individual against his/her folly.<sup>25</sup>

For that reason, individual rights in certain circumstances are curtailed and kept within reasonable bounds. Factors which influence the placement of this limitation are said to include the nature and extent of the interests involved, the motives of the parties and the

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<sup>24</sup> Carstens and Pearmain (2007) 883. Section 6 of the *National Health Act* 61 of 2003 read with ss7, 8, 9 of the said Act provide as follows: "*S6(1) ..... every healthcare provider must inform a user of (a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interest of the user; (b) the range of diagnostic procedures and treatment options generally available to the user; (c) the benefits, risks, costs and consequences generally associated with each option; and (d) the user's right to refuse and explain the implications, risks, obligations of such refusal.*" Section 7 of the Act deals with the situation where the user cannot consent and the consent has to be given by another person etc. Section 7(2) provides for definition of 'informed consent' meaning "*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*" Section 8 of the Act deals with a user's right to self determination in the following terms: "(1) a user has a right to participate in any decision affecting his or her personal health and treatment .....". Section 9 of the Act provides for health service without consent.

<sup>25</sup> Van der Walt (1979) 53-54; See also Strauss (1964) *SALJ* 139 182-184.

social purpose of the consent or assumption of risk.

## 4.2 FORMATION OF THE CONTRACT - SOUTH AFRICA

### 4.2.1 Intention to Create Legal Relations

One of the cornerstones of the doctor-patient relationship in forming a contract is the intention by the parties to create a legal relationship.<sup>26</sup>

It involves the purchase of professional services and/or sale of medical equipment<sup>27</sup> where the parties, both the doctor/hospital and the patient are known to each other. For the legal relationship between the doctor/hospital and patient to be valid the parties must be competent to conclude the contract.<sup>28</sup> In the Law of Contract it is commonly described as 'the meeting of minds' between the contracting parties when the contract is formed.<sup>29</sup>

The validity thereof, as will be seen hereinafter, will depend on whether the patient is legally capable of consenting.

### 4.2.2 The Capacity to Contract

One of the *essentially* for a valid contract between the doctor/hospital and the patient is that the parties must have the necessary contractual capacity at the time when the

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<sup>26</sup> The above principle is founded on the definition given to contract in general by the authors De Wet and Van Wyk (1978) 23ff namely: "An agreement entered into with the intention of creating an obligation or obligations." A similar definition is given to a contract by Gordon, Turner and Price Medical Jurisprudence (1953) 69 namely: "An agreement between two or more persons which create or are intended to create a legal obligation."

<sup>27</sup> See Van Oosten *Encyclopaedia* (1996) 53 - 54 who uses the examples of a patient undergoing dental treatment and arising from such treatment the dentist supply and fits the patient with a denture. See also: *Tulbach v Marsh* 1910 (TPD) 453; *Sutherland v White* 1911 (EDL) 407; *Noakes v Niland* 1914 (CPD) 976; *Kruger v Baltman* 1933 (1) PH 306; *S v Progressive Dental Laboratory (Pty) Ltd* 1965(1) SA (T) 195; See also Strauss (1991) 69. A further example is where a patient undergoes treatment in a hospital and the hospital thereafter supplies and fits an artificial leg for the patient. See *Shields v Minister of Health* 1974 (3) SA 276 (RAD).

<sup>28</sup> This is referred to by Strauss (1991) 3 as "the capacity of the doctor and patient to contract." See also Van Oosten *Encyclopaedia* (1996) 65 who refers to the competency to contract as "the legal capacity to consent." See also Gordon Turner and Price (1953) 71 who refers to the doctor's 'contractual capacity'. See further Van der Merwe and Olivier *Die Onregmatige Daad in die Suid-Afrikaanse Reg* (1985) 91 who define that legal capability as "a person is capable of forming an intention when he or she is intellectually of sufficient maturity to understand the implications of his or her acts and when he or she is not mentally ill or under the influence of drugs which have an impairing affect on his or her brain." See also Claassen and Verschoor *Medical Negligence in South Africa* (1992) 60 in this regard.

<sup>29</sup> See Christie (2006) 22 - 23 who refers to this act as "A coincidence of the wills or consensus ad litem." See also Joubert Volume 5 Part 1 (1994) par 126. See further Van Oosten *Encyclopaedia* (1996) 63 who states that the contractual relationship between the doctor/hospital and patient "presupposes consensus ad idem between the parties."

contract is entered into. A valid doctor/hospital-patient agreement will therefore depend, primarily, on whether the patient is legally capable of consenting to be diagnosed or treated.

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It is essential therefore, that, save for the exceptions enunciated in the footnote hereunder, as a general rule, the doctor/hospital first establishes whether the patient has the necessary capacity to enter into an agreement with the doctor/hospital.

The patient's capacity to contract is dependent on whether he/she is in a position to consent to the medical treatment or surgery etc. Currently South African legislation governs various aspects of consent.<sup>31</sup> The legislation includes the *National Health Act*,<sup>32</sup> the *Mental Health Care Act*,<sup>33</sup> the *Child Care Act*,<sup>34</sup> and the *Choice on Termination of Pregnancy Act*.

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The following broad categories of people are influenced by the fore stated legislation, namely, capacitated adult patients, minor patients, mentally ill patients, consent to termination of pregnancy.

#### 4.2.2.1 Adult Patients

In the case of adults, normally the patient himself or herself will consent to be diagnosed or treated.

One of the pre-requisites is that the patient be of sound or sober senses or free of intoxication or drug impediments or unconscious or in a complete state of shock before it may be assumed that the patient has the necessary legal capacity to enter into such an

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<sup>30</sup> For the general requirement of contractual capacity see Christie (2006) 227ff; Lubbe and Murray (1988) 20. For the requirement in the medical sense see Strauss (1991) 3 who state that: "*Legally the doctor's right to treat or to operate is based entirely on the patient's consent apart from those cases where the patient is under a statutory duty to submit to for example a vaccination or an examination for the purposes of public health and apart from emergency cases where a patient is brought to a doctor in an unconscious or semi-conscious state.*"

<sup>31</sup> Carstens and Pearmain (2007) 897ff.

<sup>32</sup> 61 of 2003.

<sup>33</sup> 17 of 2002.

<sup>34</sup> 38 of 2005.

<sup>35</sup> 92 of 1996.

agreement.<sup>36</sup>

Although the concept, adulthood, commonly referred to a person who has reached the age of majority (21 years of age), significantly, in terms of the *Child Care Act*<sup>37</sup> any person over the age of 18 years shall be competent to consent to the performance of any medical operation upon himself.<sup>38</sup> More recently, the age of majority which was previously in place, has now been repealed and a person who attains the age of 18 is now deemed to be a major.<sup>39</sup>

In instances concerning married couples, the general rule is that each individual spouse, either husband or wife, is fully entitled to consent independently to any medical treatment, notwithstanding the fact that they are married in community of property.<sup>40</sup> Where the procreative powers of a spouse may be terminated by an operation, as in a case of sterilization, the doctor should ascertain if the consent of the patient's spouse has been obtained. But if the other spouse does not consent, the doctor may still carry out the procedure.<sup>41</sup>

Where an emergency situation prevails and one cannot rely on the patient to exercise his or her individual capability, this pre-requisite is dispensed with and the operation may take place without the direct consent of the patient, provided, the requirements of the *National Health Act*<sup>42</sup> are complied with. In context of consent requirement relating to adults, reference should be made to section 7(1) of the *National Health Act*,<sup>43</sup> which provides for proxy or substituted consent to medical interventions by someone else on behalf of the patient who himself/herself cannot consent. The provision states the following:

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<sup>36</sup> Dada and McQuiod-Mason *Introduction to Medico-legal practice* (2001) 8. See especially the case of *Recsei's Estate v Meine* 1943 EDL 277 wherein the court held " " ..... Ordinarily the consent of an adult in full possession of his mental faculties ..... would be sufficient authority for the performance of a surgical operation upon him.

<sup>37</sup> 38 of 2005.

<sup>38</sup> S39 (4) (a) of the *Child Care Act* 74 of 1983; See the discussion of Carstens and Pearmain (2007) 898.

<sup>39</sup> See the *Child Care Act* 38 of 2005.

<sup>40</sup> Dada and McQuiod-Mason (2001) 9.

<sup>41</sup> The reason therefore is that the consent of the spouse is not legally necessary. See Dada and McQuiod-Mason (2001) 9. The Constitution also provides that every person has the right to make decisions concerning his or her reproduction. See Section 12 (2) of Act 108 of 1996.

<sup>42</sup> 61 of 2003.

<sup>43</sup> 61 of 2003.

Subject to section 8, a health service <sup>44</sup> may not be provided to a user, <sup>45</sup> without the user's informed consent, unless:

- (a) the user is unable to give informed consent and such consent is given by a person -
  - (i) mandated by the user in writing to grant consent on his or her behalf; or
  - (ii) authorized to give such consent in terms of any law or court order.
- (b) the user is unable to give informed consent and no person is mandated or authorised to give such consent, and the consent is given by the spouse or partner of the user or, in the absence of such spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the user, in the specific order as listed;
- (c) the provision of a health service without informed consent is authorised in terms of any law or a court order;
- (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) 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."

#### 4.2.2.2 Juvenile Patients

Generally, in the case of minors because of their age, save for specific legislative provisions to the contrary, they cannot enter into any agreement with a doctor/hospital. It is the parents or guardian who enters into agreements on their behalf. <sup>46</sup>

The doctor will, as a general rule, be perfectly safe in relying upon the consent of either the mother or father. In the case of adopted children or orphans, the person who is the legal guardian of the child has the authority to enter into an agreement with the doctor/hospital on behalf of the child. <sup>47</sup>

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<sup>44</sup> Defined in the Act as "health care services, including reproductive health care and emergency medical treatment contemplated in section 27 of the Constitution, basic nutrition and basic health care services is contemplated in section 28(1)(c) of the Constitution, medical treatment contemplated in section 35(2) of the Constitution; municipal health services."

<sup>45</sup> "User" the term now employed by the Act to describe the patient, is now defined as "the person receiving treatment in a health establishment, including receiving blood of blood products, or using a health service, and if the person receiving treatment or using a health service is (a) below the age contemplated in s39(4) of the Child Care Act, "user" includes the person's parents or guardian or another person authorized by law to act on the first mentioned person's behalf; of (b) incapable of taking decisions, "user" includes the person's spouse or partner or, in the absence of such spouse or partner, the person's parent, grandparent, adult child or brother or sister, or another person authorized by law to act on the first mentioned person's behalf". See the discussion by Carstens and Pearmain (2007) 899.

<sup>46</sup> Dada and McQuoid-Mason (2001) 10ff; Strauss (1991) 6-7, 211-212; See also *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 714 (T); *G v Superintendent Groote Schuur Hospital* 1993 (2) SA 255 (C) 262.

<sup>47</sup> See Strauss (1991) 4 - 5; See also Van Oosten Encyclopaedia (1996) 66; Dada and McQuoid-Mason (2001) 10 - 12; Claassen and Verschoor (1992) 60; McQuoid-Mason and Strauss (1983) Volume 17 Par 193; See also Gordon



In certain instances where the patient, in terms of the common law, delegates certain of his parental powers to another person who acts *in loco parentis* (on behalf of the parent) for example a teacher, a youth leader or a relative in whose care the child is temporarily. Where a parent has expressly or tacitly authorised such a person to enter into an agreement with a hospital/doctor for medical intervention for the minor child on his or her behalf, that person has the legal capacity to contract.<sup>48</sup>

Despite the common law position which, as was discussed herein before, limits the contractual capacity of minors in general, certain legislative provisions vitiate the general limitations.<sup>49</sup>

#### 4.2.2.3 Mentally ill Patients

The consent requirements for mentally ill patients are to be found in the recently passed *Mental Health Care Act*.<sup>50</sup> In terms of the legislation mentally ill patients are regarded as "mental health care users" and include *inter alia* the following categories of persons:

*"A person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, state patient and mentally ill prisoner."*<sup>51</sup>

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Turner and Price (1953) 79 who expresses the view that *"The contractual capacity of the minor is subject to the control of his parent or guardian. Generally speaking, he is not bound by any contract into which he may enter if he does not have the consent of his parent or guardian with the following exceptions namely:*

- (a) *The parent or guardian may ratify the contract after it has been signed;*
- (b) *The minor may ratify the contract on attaining majority;*
- (c) *The minor may be "tacitly emancipated". The practitioner will be well advised not to rely on it unless advised."* See also Strauss and Strydom (1967) 188.

<sup>48</sup> Strauss (1991) 6-7; Van Oosten (1996) 66; Dada and McQuoid-Mason (2001) 10ff. The court may also exercise the power of an upper guardian in instances where a parent or guardian declines to furnish consent. See *Seetal v Pravitha NO 1983 (3) SA 827 (D)* *S v L 1992 (3) SA 713 (E) 723*; *O v O 1992 (4) SA 137 (C) 139*.

<sup>49</sup> The *Children's Act 38 of 2005* and especially Section 39(4) thereof provides *"any person over the age of 18 may enter into an agreement with a doctor/hospital independently of his or her parents to the performance of any surgical procedure; and any person over the age of 14 years is given the authority in terms of this act to enter into an agreement with a doctor/hospital without the assistance of his parents to medical treatment."* More recently in terms of The Choice on Termination of Pregnancy Act 92 of 1996 and especially Section 5 thereof which *"provides a minor of whatever age with the legal capacity to enter into an agreement with a doctor/hospital for the purpose of securing the termination of the pregnancy provided certain requirements are met. The requirements are: (1) The minor must be of sane and sober mind and conscious at the time the agreement is entered into and the minor is advised by a medical practitioner or a registered midwife to consult with her parents provided that the termination of the pregnancy shall not be denied because the minor does not choose to consult the parents."* See the general discussion on the legislative provisions by Carstens and Pearmain (2007) 902-905.

<sup>50</sup> Act 17 of 2002.

<sup>51</sup> Sec 1 of Act 17 of 2002.

Where the person concerned is below the age of 18 years or is incapable of taking decisions, the following persons may make decisions on their behalf:

- (i) Prospective user;
- (ii) The person's next of kin;
- (iii) A person authorized by any other law or court order to act on that person's behalf;
- (iv) An administrator, appointed in terms of this Act; and
- (iv) An executor of that person's estate .....

The Act also makes provision for voluntary and involuntary care and rehabilitation affecting mental care users.<sup>52</sup>

It is thus clear from the provisions of the Act that a mentally ill person may generally be able to consent to care, treatment and rehabilitation.<sup>53</sup> The law has thus changed from the common law position, in that, where a person is mentally ill does not *per se* imply that such a person is unable to consent.

But where the mentally ill person is unable to consent, a court may issue the necessary court order.<sup>54</sup>

#### 4.3 Agreement for Performance

The foundation of the nature of the agreement for performance between the doctor/hospital and the patient is based on the general definition of a contract.<sup>55</sup> The agreement for performance, it is submitted, is one of the obligations which flow from the agreement entered into by the parties concerned.

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<sup>52</sup> Section 9(1) of the Act provides for treatment or rehabilitation or admit a mental health care user only if:-  
(a) the user has consented to the care, treatment and rehabilitation or to admission;  
(b) authorized by a court order or a review norm; or  
(c) due to mental illness, any delay in providing care, treatment and rehabilitation services 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."

<sup>53</sup> Carstens and Pearmain (2007) 900.

<sup>54</sup> Carstens and Pearmain (2007) 900.

<sup>55</sup> See Joubert, Harms and Rabie Volume 5 Part 1 (1994) Par 124 who, despite numerous varying definitions been given to a contract, prefers the definition given by the authors De Wet and Van Wyk (1992) 124 namely "A contract is an agreement entered into with the intention of creating an obligation or obligations. See also Gordon, Turner and Price (1953) 69.

For that reason it is suggested that the agreement for performance between the doctor/hospital and patient can be defined as: The contemplated agreement<sup>56</sup> between the doctor/hospital and the latter's representative,<sup>57</sup> who are both competent,<sup>58</sup> upon legal consideration,<sup>59</sup> to do or to abstain from doing some act.<sup>60</sup>

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<sup>56</sup> See Van Oosten *Encyclopaedia* (1996) 63 who states that "*the contemplated agreement is concluded when consensus ad idem is reached between the parties of which the patient's effective consent is fundamental.*" See also Strauss and Strydom (1967) 105; Strauss (1991) 3; Claassen and Verschoor (1992) 115; See further Gordon, Turner and Price (1953) 70. For that reason Joubert, Harms and Rabie Volume 5 Part 1 (1994) Par 126 suggest that there cannot be an agreement unless "*there has been a complete meeting of the minds that is unless the intention of the one corresponds exactly to that of the other.*" The effect of a lack of consensus is to nullify the purported contract or to make the agreement void. See Joubert, Harms and Rabie *LAWSA* Volume 5 Part 1 (1994) see also Strauss and Strydom (1967) 106 who share the view that "*an agreement for performance will be voidable if the contents of the agreement is vague or an error in negotia has occurred.*" Furthermore it will also be voidable if the doctor, despite it been indicated, fails to illicit the patient's informed consent. For that reason it has been suggested that any unusual proceedings contemplated by the doctor should first be discussed with the patient. See Strauss (1991) 91.

<sup>57</sup> For a discussion as to whom usually enter into an agreement see Van Oosten *Encyclopaedia* (1996) 54; See also Strauss (1991) 3; Claassen and Verschoor (1992) 115; Strauss and Strydom (1967) 104; McQuoid-Mason and Strauss Volume 17 (1983) 147. See further Dada and McQuoid- Mason (2001) 5 who distinguishes between the doctor in private practice in which a direct agreement for performance between doctor and patient takes place and that of a patient who presents for medical treatment by the staff at a hospital in which event the patient enters into an agreement for performance with the relevant hospital authority regardless of it being a private or provincial authority. See in this regard also *Friedman v Glicksman* 1996 (1) SA 1134 (W); See further Strauss *Legal Handbook for Nurses and Health Personnel* Ted (1992) 5.

<sup>58</sup> Although there may in fact be consensus between two persons and the content of that consensus may be that they wish to create obligations, no valid, enforceable obligations will arise from such consensus if one or both of the parties did not have the necessary capacity to contract. In other words, they are not competent to perform judicial acts. See Joubert, Harms and Rabie Volume 5 Part 1 (1994) Par 158 for a discussion as to who is competent and who is not in a medical context.

<sup>59</sup> Legal consideration entails that despite parties agreeing to bind themselves legally, enforceable obligations will arise only if the contract is legal or lawful. Where the making of the agreement is tainted in any way by duress and undue influence, i.e. if the Plaintiff in the contract suit took unfair advantage of a trusting relationship with the Defendant the defence may well be successfully invoked depending on the circumstances. See generally Christie - 2006 259; Christie *The Law of South Africa* First re-issue Volume 5 Part 1 (1994) Par 154. See also Van Oosten *Encyclopaedia* (1996) 55 for a medical context setting. See also Strauss and Strydom (1967) 110 who state that "*the agreement between the doctor and patient as with any other agreement must be valid. Where for example the parties agree to an unlawful abortion, such an agreement shall be invalid.*" Likewise with duress or undue influence Strauss and Strydom (1967) 110 relying on the Common Law position as advocated by Voet endorse the principle that "*it is reprehensible that a doctor exploits a patient's position owing to the patient's mental or physical position.*" See the *Digesta* 2.14.19. See also Gordon, Turner and Price (1953) 71 who is also protective of a patient who fears death or even illness and who is at the mercy of an unscrupulous physician. The authors suggest that our courts should follow the strict rules laid down by the English Law in "*throwing the onus upon the physician to show if he can, that he had in fact brought no moral pressure to bear upon his patient, failing whom the gift or legacy may be declared void at the suit of an interested party.*" The afore mentioned matter also received the attention of our courts. It has been decided before that: "*Undue influence on a doctor's part which resulted in his patient, an old sick, weak and weary farmer donating four farms to the doctor, was held to constitute a ground for restitutio in integrum.* See in this regard *Preller v Jordaan* 1956 (1) SA 487 (A). Also the claim of a doctor who had treated a patient free of charge over a number of years for fees from her estate after her death was refused on the basis that he had not proved the existence of an agreement which entitled him to such fees. See also *Faure v Britz* 1981(4) SA 346 (O). See also *Armstrong v Magid* 1937 A.D. 260,



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*Katzwellenbogen v Katzwellenbogen* (WLD) 1947 (2) S.A.L.R. 528.

<sup>60</sup> Generally, in the absence of an express agreement between the doctor/ hospital and patient or his or her representative, the agreement for performance entails that the doctor/hospital ordinarily undertakes to examine the patient and/or diagnose his or her ailment and/or treat his or her condition with professional care and skill. That the doctor has undertaken to do or not to do has been interpreted by our academic writers as follows: See Van Oosten *Encyclopaedia* (1996) 55 "*The doctor undertakes no more than to treat or operate upon the patient with the amount of competence, care and skill which may be expected, from a medical practitioner in the particular branch of the profession.*" See also McQuoid-Mason and Strauss Volume 17 (1983) 144; Strauss and Strydom (1967) 106; Claassen and Verschoor (1992) 115 - 116; Dada and McQuoid-Mason (2001) 5. It does not however, in the absence of an express or implied warranty to that effect, include a guarantee that the patient will be cured or that the intervention will be a success. See Van Oosten *Encyclopaedia* (1996) 55; Strauss and Strydom (1967) 106; *Contra* Claassen and Verschoor (1992) 116 who express the view that "*a physician is free, however, to warrant explicitly that he will cure a patient, in which instance he will expose himself to a claim for damages based on breach of contract should he be unable to fulfil his undertaking.*" See also McQuoid-Mason and Strauss *LAWSA* Volume 17 (1983) 144. See further Strauss (1991) 329 who states that '*should the doctor be so bold as to guarantee a cure, he assumes a special risk of liability in the event of him being unable to fulfil his guarantee.*' In a number of cases our courts have held that by undertaking a case, a doctor does not guarantee that the patient will be cured of his disease (cf. the judge's remarks in *Buls and Another v Tsatsarolakis* 1976 (2) SA 891 (T) at 893; *Behrmann and Another v Klugman* 1988 (4) SA 6 (W). In *Chalk v Fassler* (1995, WLD, unreported, discussed by Strauss 1995 (4) *SAPM* 12 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.*" The court remarked further: "*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.*" The effects of the doctor's failing to fulfil his undertaking have received the attention of our courts in a number of cases. 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. See *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) See *Recsei's Estate v Meine* 1943 EDL 277. A doctor who has undertaken to forward for analysis a biopsy taken of a tumour in a patient's nose, but through negligence causes 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 (sterilization) on a woman, who subsequently fell pregnant and gave birth to a child. The above statement needs to be qualified in that an undertaking by a doctor to examine the patient and to diagnose his or her condition does not amount to an undertaking to treat the patient personally. See Dada and McQuoid-Mason (2001) 5 who expresses the view that '*in some instances it may be necessary for the doctor to refer the patient to a specialist or other professional.*' A failure to do so '*when the physician lacks the necessary skill may constitute negligence.*' See also Van Oosten *Encyclopaedia* (1996) 55 who opines: "*If the diagnosis and/or treatment falls outside the doctor's sphere of training or specialization, he or she is under a duty to refer the patient to or to call in a specialist.*" In that event Van Oosten *Encyclopaedia* (1996) 55 states that: "*If the doctor is in private practice, the patient and the specialist have to enter into a separate and independent agreement for purposes of a specialized diagnosis and/or treatment.*" See further Dada and McQuoid-Mason (2001) 5; Strauss and Strydom (1967) 106; See also further *Kovalsky v Krige* p. 823; *Coppen v Impey* p. 314; *Van Wyk v Lewis* AD p. 456; *Verhoef v Meyer* 1975 (1); 1976 (unreported, discussed on Strauss (1991) pp. 35, 36); *Behrmann v Klugman* 1988 (W) (unreported, discussed on Strauss (1991) pp. 41 176-177; *Chalk v Fassler* 1995 (W) (unreported, discussed by Strauss SA 1995 (4) *SAPM* p. 12) *Buls v Tsatsarolakus* P. 393 (in which the question was raised but not decided. In more serious matters Strauss and Strydom (1967) 224 hold the view that "*the operation agreed to or the treatment undertaken may not materially be deviated from save for emergency situations.*"

The agreement for performance between the doctor and patient is said to also entail that the doctor is expected to perform only that which he has undertaken to do.<sup>61</sup> Unless the doctor expressly guarantees a cure, the patient might not be able to claim damages for breach of contract in the event of the doctor failing to fulfil his undertaking. But in the general course of events the doctor undertakes no more than to treat the patient with the amount of skill, competence and care which may reasonably be expected of practitioners of his branch of medicine.

Likewise, when a patient enters a hospital for treatment and/or confinement and signs an admission form, a contractual relationship between the hospital and patient comes into being. One of the terms of which is the implied term that the hospital and its staff owe the patient a duty to take care.<sup>62</sup>

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<sup>61</sup> Generally a doctor/hospital may not abstain from that what he/she or it has undertaken to do, nor, may the doctor/hospital depart or deviate from the express or implied terms of the agreement. If the doctor/hospital does it will constitute a breach of contract and may result in the doctor/hospital being held liable for patrimonial loss but not for non-pecuniary damages. The doctor/hospital shall also be liable to recover a fee for services rendered. See Van Oosten *Encyclopaedia* (1996) 56; See also Strauss and Strydom (1967) 107; See further Claassen and Verschoor (1992) 116 who are of the view that: "*Where a practitioner digresses from the explicit instructions of a patient, or fails to treat the patient in the manner tacitly agreed upon or explicitly warranted, he will be committing breach of contract and he may be denied the right to recover any remuneration for the services he had rendered.*" See also further McQuoid-Mason and Strauss *LAWSA* (1983) 145; *Contra* Gordon, Turner and Price (1953) who opine that besides claiming damages for breach of contract a patient may also repudiate the agreement or seek an interdict depending on the circumstances; See further Dada and McQuoid-Mason (2001) 5 - 6; Strauss and Strydom (1967) 107 also point out that a physician can be delictually responsible where he performs another operation than the one the patient has consented to. Our case law has also recognised the remedies available to a patient where a doctor departs from the patient's express instructions or fails to treat the patient in the manner tacitly agreed upon. In that event 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. See *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). See *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. See *Hewat v Rendel* 1925 TPD 679. See further in *Administrator of Natal v Edouard* 1990 (3) SA 581 (A) in which the 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 (sterilization) on a woman who subsequently fell pregnant and gave birth to a child.

<sup>62</sup> In so far as the South African legal position is concerned see generally Strauss (1991) 9; See also Cronje-Retief - (2000) 89, 421 who advocates that the duty to take care "*is a strict duty*", "*a non-delegable duty*" in which the hospital has a primary duty to the patient:

- (i) *to ensure that the duty is performed; and*
- (ii) *To be responsible for the manner in which it is performed."*

See also Van Dokkum "Medical Malpractice in South African Law" *De Rebus* 1996 252 who describe the duty to take care to include:

- deciding whether to undertake the case;
- taking a proper case history;
- making careful diagnosis; and
- properly informing the patient about any proposed treatment or operation and the inherent (material) risks of treatment). A duty of care is similarly imposed when the patient's consent to such treatment is



obtained, and in the administration of that treatment or the performance of an operation or medical procedure.

In so far as case law is concerned see *Administrator Natal v Edouard* 1990 (3) SA 581 (A) in which the court found that the hospital liability was established on account of breach of contract in failing to perform the operation they had agreed upon. Van Heerden JA in considering the action state at 588 D-F that: "It was common cause that the respondent suffered damages (i.e. child raising expenses) as a result of the breach, that such damages were a direct and natural consequence thereof, and that the loss was contemplated by the parties as a likely consequence of failure to perform the agreed sterilization operation, more particularly because, to the knowledge of the Administration, the respondent and Andrae could not afford to support any more children. The claim therefore satisfies all the requirements of our law for the recovery of damages flowing from breach of contract." See also the case of *Silver v Premier, Gauteng Provincial Government*, 1998 (4) SA 569 (W); per Colette J at 574 J-575 B: The plaintiff's claim was 'founded in contract and, in the alternative, in delict. ... The loss sustained by the plaintiff is said to have been caused by the breach of an implied term of an agreement that the hospital through its staff and employees would exercise due care, skill and diligence in providing nursing care. Precisely the same facts are relied upon as constituting a breach of the implied term of the duty of care owed to the plaintiff.' The latter 'duty of care' (formulation) referred to, could also have founded another alternative/sovereign legal ground for hospital liability, namely direct liability. *Mukheiber v Raath and another* 1999 (3) SA 1065 (SCA). This was a case with similar facts to the case of *Administrator, Natal v. Edouard* 1990 (3) SA 581 (A) but the former claim was founded in delict." The legal position in England with regard to a hospital's duty of care to its patients is recognized by both academic writers as well as the English courts. See Kennedy and Grubb *Medical Law: Text with Materials* (1995) describe the duty of care as "a direct or personal or corporate duty of care." See also Brazier *Medicine, Patients and the Law* (1992) 88 - 89 who state the hospital authorities is "directly responsible for its own breach of contract" which is preferred to the term "direct liability." One of the first English cases which dealt with hospital liability and which affected all modern developments of law in this field is the case of *Cassidy v Minister of Health* (1951) 2 KB 343. Denning LJ describes the hospital authorities' duty of care in the treatment of their patients as one purporting "to involve the use of reasonable care and skill to cure patients of their ailments." He described the duty to use care as follows:

"In my opinion authorities who run a hospital, be they local authorities, government boards, or any other corporation, are in law under the selfsame duty as the humblest doctor; whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves: they have no ears to listen through the stethoscope, and no hands to hold the surgeon's knife. They must do it by the staff which they employ, and if their staffs are negligent in giving the treatment, they are just as liable for that negligence as is anyone else who employs others to do his duties for him. Once they undertake the task, they come under a duty to use care in the doing of it, and that is so whether they do it for reward or not." In *Roe v Minister of Health* (1954) 2 QB 66 Denning LJ again had to decide on whether the hospital authority was negligent or not and gave a summary of crucial questions to be answered in every case:

- (i) The first question in every case is whether there was a duty of care owed to the plaintiff; and the test of duty depends, without doubt on what you should foresee.
- (ii) The second question is whether the neglect of duty was a 'cause' of the injury in the proper sense of that term; and causation, as well as duty, often depends on what you should foresee.
- (iii) The third question, remoteness of damage, comes into play only when the first two questions - duty and causation - are answered in favour of the plaintiff. The extent of the liability is found by asking: "Is the consequence fairly to be regarded as within the risk created by the negligence?"

The position in the United States of America is described by academic writers as "corporate or direct liability arising from a breach of the hospital's independent direct duty of care which it owes the patients."

See Cronje-Retief (2000) 354; See also Werthmann *Medical Malpractice Law: How medicine is changing the Law* (1984) 19; See also Pozgar *Legal aspects of Health Care Administration* (1993) 207 - 208; See further Mason and McCall-Smith 1987 *Encyclopaedia* 482. According to Pozgar (1993) 207 - 208 "The direct duties which a corporation owes the general public and its patients, usually arising from statutes, regulations and principles of law which the courts develop and internal operating rules of the institution." In one of the first cases in the United States namely *Darling v Charleston Community Memorial Hospital* 50 Ill APP. 2d 254, 20 NE 2d 149 (1964) AFF 1d 33 Ill 2d 326 211 NE 2d 253 (1969) which formally introduced corporate hospital liability as a legal ground. The court held in determining whether a hospital was negligent the court must start off by looking at "the duty or standard of care the hospital owed its patients." The court held that "the duty or standard of care contained in the regulations and bylaws demonstrate that the medical profession and other responsible authorities regard it as both



#### 4.4 Absence of Illegality

A further requirement for a valid agreement between the doctor/hospital/other health care provider and the patient, it is submitted, is that the agreement between the doctor/hospital/other health care provider and patient must not be against public policy or against good morals.<sup>63</sup>

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*desirable and feasible that a hospital assume certain responsibilities for the care of the patient.*" The court then highlighted the following duties owed by hospital authorities to their patients:

- (i) the duty of nurses to adhere to proper procedures by supervising patients adequately and regularly,
- (ii) the duty that nurses should inform medical staff, the attending physician or the hospital administration of (dangerous) conditions,
- (iii) the duty to obtain the necessary consultation, especially where complications had developed,
- (iv) The duty to review the (independent contractor) physician's work.

In a later judgement of *Gonzales v Work No 228566* (CAL SIP CT Sacramento County) (filed Nov 19, 1973) 1974 the court held that the hospital's corporate liability was founded on *"its duty to protect patients from malpractice by members of its medical staff."* The court held if the hospital knew, had reason to know or should have known that negligent acts were likely to occur, the hospital or the hospital governing basis was corporately responsible for the (negligent) conduct of its medical staff. The North Carolina Court of Appeals in *Boast v Riley* 44 No APP 638, 262 SE 2d SE 2d 391 (1980) recognised the direct hospital duties in the state of North Carolina when it stated: *"We acknowledge that a breach of any such duty may correctly be termed corporate negligence, and that our state recognised this as a basis for liability apart and distinct from respondent superior."*

In this case the court interpreted the hospital's duty to take care to include: *"To monitor and overall the physicians prescribing and rendering treatment and medical care at the facility."* In a succeeding case of *Johnson v Misericordia Community Hospital* 99 Wis. 2d 708, 301 NW 2d 158 1981 Coffey J recognised that hospitals owe a duty of ordinary care in selecting and maintaining only qualified members on their medical staff, to ensure quality care, diagnosis and treatment of their patients. It was confirmed and concluded that *"a hospital is under a duty to execute reasonable care to permit only competent medical doctors the privilege of using their facilities."* In the case of *Elam v College Park Hospitals* 4 CIV. No 24479 (CAL.CT APP filed May 27, 1982) the court was also asked to assist the hospital's duty of care towards its patients in employing independent physicians who performed surgery on hospital patients. The court held that the hospital owed a duty of care towards the patients *"through careful selection and review, as well as a duty of continuing evaluation to monitor, review and trends in the quality of treatment given by a staff physician over time to ensure quality or adequacy of medical care at the hospitals."*

<sup>63</sup> See Gordon, Turner and Price (1953) 72. The authors discuss the general principles of the illegality of contracts without going into medical contracts. They conclude *".... An illegal contract is void in law, and no court will enforce it."* The authors also identify two causes for illegality namely acts contrary to statutes or the common law. Support for this view is found in the general law of contract. See Van Ransburg, Lotz and Van Rhijn *LAWSA* Volume 5 Part 1 (1994) 214. The authors opine that a contract is illegal *"when its conclusion, its performance or its object is expressly or impliedly prohibited by legislative enactment or is contrary to good morals or public policy. The absence of illegality which renders agreements void in the common law rule ex turpi causa non obitur actio."* See I3 19 24 D2 14 27 4 which makes no distinction between immoral (turpis) and an illegal (iniustus) contract. For a discussion of contracts contrary to legislative enactment see Van Ransburg, Lotz and Van Rhijn *LAWSA* Volume 5 Part 1 (1994) 215; See also Christie (2006) 391. The writer states that *"contracts that are void as a result of statutory illegality cannot be subsequently ratified nor its voidness renounced or waived."* For a discussion of the common law illegality and unenforceability of contracts see Van Ransburg, Lotz and Van Rhijn *LAWSA* Volume 5 Part 1 (1994) 215. The authors take the view that *"public policy requires that a contract should not be clearly inimical to the interests of the community, nor contrary to law or morality, nor should it encounter to social or economic experience."* The authors continue to add: *"Freedom of contract, backed by the necessity to do simple justice between man and man, is a constituent of public policy."* But caution the authors: *"The power to declare a contract contrary to public policy should be exercised sparingly and only when the impropriety of the contract and the event of public harm are manifest."* See also Christie (2006) 398 400. The author when considering the effect of the judgement *Sasfin (Pty) Ltd v Beukes* 1989 (1) SA 1(A) in pronouncing on the illegality

It is against this background that an investigative study is conducted with this thesis, the focal point of which is to determine whether disclaimers (or exculpatory clauses) in hospital

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or unenforceability of contracts by common law, comments as follows on public policy which influences the illegality of contracts. The author in concluding that *"public policy is a question of fact not law"* which changes with *"the general sense of justice of the community, the boni mores, manifested in public opinion"* expresses the view that *"in pondering these words it is necessary to draw a distinction between superficial public opinion, which can swing like a weather cock, and seriously considered public opinion on the general sense of justice and good morals of the community. It is the latter, not the former, to which the courts must direct their attention."* See further 402 - 403. The author is particularly critical on the affects of the provisions of the Constitution of the Republic of South Africa Act 108 of 1996 and states: *"By accepting the constitution as a reliable statement of public policy, a court would have no difficulty in declaring a contract which infringed a provision of the Bill of Rights to be contrary to public policy and therefore unenforceable."* Other factors which may influence the public's indignation against the upholding of the legality of certain contracts include good faith. See in this regard Fletcher, *"The Role of Good Faith in the South African Law."* It is particularly against the background of linguistic diversity in South Africa that the writer argues: of Contract" *Responsa Meridiana* (1997) 1 - 14. The writer in relying on the spirit of the Bill of Right argues that: *"The spirit of the Bill of Rights certainly leans towards such notion as good faith in contravening."* It is particularly against the background of linguistic diversity in South Africa that the writer argues: *"Many people do not understand English or Afrikaans and are hence predisposed to being victims of unfair contractual terms, particularly via the widespread use of standard contracts. Legislation entrenching good faith will go some way towards ameliorating this problem as drafters of contracts will be wary of constructing agreement that could be struck down by the Courts. With or without specific preventative measures, the net effect of such legislation would be preventative in itself. Suffice it to say that contemporary South Africa is readier than ever for the legislative entrenchment of good faith in contracting."* See also Van der Walt: *"Aangepaste Voorstelling vir 'n Stelsel van Voorkomende Beheer oor Kontrakteer Vryheid in die Suid-Afrikaanse Reg"* *THRHR* 1993 65 - 82. The writer in advancing a strong argument for the introduction of legislation to control standard contract terms which often are immoral and have unjust results state: *"Several additional arguments in favour of a general criterion in terms of good faith rather than public policy, are offered. Amongst other reasons, good faith is locally and internationally acknowledged as the term in which the ethical requirement set by public policy is expressed when public policy is considered in the contractual field. Using public policy will lead to the question who the public in public policy is. Employing fairness to express the general criterion would not improve matters either, because it stresses generalism and stands in stark contrast to the individualistic bent of our law of contract. Good faith thus represents the collective experience of our legal culture and has been integrated into our approach to contractual relationships as well as that of comparable legal systems."* See also Zimmerman and Visser *Civil Law and Common Law in South Africa* (1996) 259 -260. The authors in making out a case for good faith influencing public interests state: *"Good faith, it could be argued, requires that parties to a contract show a minimum level of respect for each other's interest. The unreasonable and one-sided promotion of one's own interest at the expense of the other infringes the principle of good faith to such a degree as to outweigh the public interest in the sanctity of contracts. Public policy, under these circumstances, rather requires the courts to refuse to enforce the contract. From the point of view of the appropriate doctrinal pigeonholes, conduct contrary to good faith may thus be classified as illegal."* See also Van Oosten (1996) 64 who discusses the influence of legally recognised consent in the doctor/patient agreements. The author expresses the view that legally recognised consent will only be attained should it *".... conform to the boni mores."* See also Dada and McQueen-Mason (2001) 8 who state that consent will only be deemed to be legally recognised consent *"if the act consented to is in accordance with public policy, not contra bonos mores."* See also Strauss and Strydom (1967) 82. The authors opine that *".... consent to a reckless medical examination with no scientific foundation or to a statutory prohibition abortion would not render the doctor's conduct lawful."* See further Strauss (1991) 286 287. The author gives an example of situations in which agreements, despite consent being obtained, the act to which the patient consents, renders the agreement invalid for example a young man who gives consent to the amputation of his perfectly normal and healthy hand in order to evade military duty and fugitive criminal who gives consent to plastic surgery with the exclusive purpose of shielding him from justice. See also Claassen and Verschoor (1992) 60; McQuoid-Mason and Strauss *LAWSA* Vol. 17 (1983) 147.

contracts have a right of existence in South Africa, <sup>64</sup> taking into consideration

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<sup>64</sup> For introductory comments see Strauss and Strydom (1967) 324. The authors take the view that where an agreement is concluded between a physician and his patient in whom the physician in the form of an indemnity clause excludes his liability, the agreement will be null and void because it is considered *contra bonos mores* in that the patient is in an unfavourable position. See also Strauss (1991) 305; The authors states that the same consideration should be applicable in the instance of hospitals where patients have suffered personal injuries; For support of this view see Cronje-Retief (2000) 440 - 441. The author takes the view those exemption clauses in which "*big institutions, corporations or other groups with unrestricted financial resources and adequate insurance exempt themselves from liability, are effectively contra bonos mores, against public policy and/or public interest and should be declared invalid by our courts.*" See further Claassen and Verschoor (1992) 103; See also Gordon, Turner and Price (1953) 188-189. Although the writers recognize the maxim "*volenti non fit injuria*" certain requirements must be met namely: "*The allegedly consenting party expressly or impliedly consent to an act of which he or she know the risks involved and appreciated them and clear evidence in this regard is shown*" where however, a medical practitioner: "*include in such a contract a term releasing him from any legal obligation to show due skill and care, for such conduct which would be grossly unprofessional and deserving of disciplinary action by the Medical Council, contracting out of liability for malpractice in such circumstances would necessitate that the Courts would declare such a contract void as against public policy, leaving the patient's right to sue for damages unimpaired. In such a case it could be argued that society cannot allow a medical practitioner to take such an advantage of his patient, in regard to whom he stands in a position of such power.*" *Contra* Burchell and Schaffer: "Liability of Hospitals for Negligence" *Businessman's Law* (1977). The authors state that "*If a patient signs a form containing such a clause (exculpatory clause) the maxim caveat subscriptor applies: Let the signatory beware.*" The authors go on to state that: "*Despite an exemption or exculpatory agreement between hospitals and patients in America being regarded as invalid, our courts are not at liberty to declare these clauses invalid.*" The authors suggest that: "*..... The most that our courts can do is to place as narrow an interpretation upon such an agreement. However, these exemption clauses which are signed by patients entering a private hospital are often warned in such explicit terms that there is little room for restricting interpretation.*" See also Van Oosten (1996) 88. The writer expresses the view that: "*Provided they are stated in unambiguous terms, exemption clauses are enforceable unless they exclude liability for intentional medical malpractice, in which case they will be regarded by the courts as contra bonos mores and, hence, as null and void.*" The writer continuous: "*Whether or not a clause excluding liability for gross medical negligence will be upheld, is at present open to doubt.*" *Contra* the most recent South African case law. In the case of *Afrox Health Care Bpk v Strydom* 2002 (6) SA 21 SCA in which the Supreme Court of Appeal was asked to pronounce on whether a contractual clause in a hospital contract which indemnifies a hospital against liability for the negligent conduct of its nursing staff was legally enforceable, alternatively whether such exemption clause militated against public policy. The court held that such a clause was valid and enforceable. Much criticism had thus far been levied at the finding. See Carstens and Kok - "An Assessment of the use of Disclaimers by South African Hospitals in view of Constitutional Demands, Foreign Law and Medico-legal Considerations" (2003) 18 *SAPR/PL* 430. The writers question *inter alia*, although the Supreme Court of Appeal confirmed that contractual clause that offends public policy, is unenforceable, it nevertheless regarded the unequal bargaining position between the parties, i.e. on the one hand the hospital as provider of health care services and on the other hand, the patient who relies on the hospital's expertise to treat him and the fact that, he was at their mercy. In this regard Carstens and Kok convincingly argues that, when regard is had to medical law/health care law, as opposed to the fragmented traditional compartments which lawyers have become familiar with namely delict, contract, criminal law, family law and public law, it is clear that a patient is in a disadvantageous position resultant in exemption clauses from a public policy point of view, being an undesirable feature in that hospitals should take responsibility for sub-standard negligence provision of services. Furthermore an exemption clause constitutes a *pactum de non petendo* in that the parties envisage the commission of an unlawful act and that, in such an event, the agreeing party agrees not to institute action which he would otherwise have enjoyed. This position according to the writers is also indicative of the validity of exemption clauses being an undesirable feature. The writers furthermore call into question the court's finding that the meaning of a disclaimer clause, in the context of the facts, should rather be interpreted restrictively to exclude gross negligence. In this regard the writers argue that in principle, it makes no difference in establishing civil or criminal liability whether the conduct complained about, arises from negligence or gross negligence.

constitutional demands,<sup>65</sup> foreign law<sup>66</sup> and medico-legal considerations.<sup>67</sup>

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<sup>65</sup> With regard to the constitutional demands, the writers Carstens and Kok (2003) 18 criticize the Supreme Court of Appeal for not upholding the argument that as providers of Health Care Services, private hospitals, should not be permitted to use disclaimers based on Section 27(1) (a) of the Constitution. The writers also criticize the court for its failure to appreciate the affect of Section 27(1) (a) on disclaimer clauses. Although the court held that a disclaimer clause in no way prevents the provision of Health Care Services, where a signed disclaimer is used as a pre-condition for admission, 'access' to health care is very much in issue. The writers also correctly point out that the court failed to uphold the respondent's argument that the Constitution demanded professional care and that a disclaimer allows hospital personnel to act in an unprofessional and negligent fashion which is in breach of the values enshrined in Section 27(1)(a) of the Constitution. To say that the hospital staff is still bound by their professional code and their negligent conduct threaten the hospital's reputation and competitiveness just does not make sense in that, although the patient may lodge a complaint with the overseeing body and the relevant staff may be disciplined, the patient is still without remedy which clearly is an undesirable consequence for professional negligence. Although the Supreme Court of Appeal points out that the contractual autonomy, as encapsulated in the common law maxim of *pacta sunt servanda* forms part of the nature of freedom and protected in terms of the Constitution, Carstens and Kok argue that the Supreme Court of Appeal over emphasizes contractual autonomy at the expense of access to health care, the latter explicitly recognised in the Bill of Rights with the former not explicitly recognized. In this regard the writers correctly opine in the context of Health Care Services, "*contractual autonomy must yield to enhancing access to professional health care services.*" Carstens and Kok are also critical of the Supreme Court of Appeal in the court's interpretation of Section 39 of the Constitution in the developing of the common law to be in line with the Constitution. The writers are highly critical of the stance taken by the Supreme Court of Appeal namely: "*Courts are obliged to follow legal interpretations of the Supreme Court of Appeal whether they relate to constitutional issues or other issues, and remain so obliged unless and until the Supreme Court of Appeal itself decided otherwise or the Constitutional Court does so in respect of a constitutional issue.*" Another section of the judgement dealing with pre-constitutional decisions which also did not escape the wrath of criticism which I submit rightly so, was the Supreme Court of Appeal's attitude in dealing with pre-constitutional decisions and the effect of Section 39(2) of the Constitution thereon. The court's attitude is: "*Where a common law rule was laid down in a pre-constitutional decision, and that rule is not directly in breach of any specific provision in the Constitution, and it is also not dependent on the boni mores or public policy, but the court is convinced that the rule must be developed to accord with the spirit, purport and purpose of the Constitution, section 39(2) yields to stare decisis and the court would be obliged to follow the pre-constitutional decision.*" The above statement according to Carstens and Kok is a shocking view in that, the Supreme Court of Appeals therewith gives out that the common law is stronger than the Constitution, ignoring the Constitutional Court's dictates in the case of *Carmichele v Minister of Safety and Security (Centre for applied legal studies intervening)* 2001 (4) SA 938 CC Paras. 33, 34 and 39 in which the rule was laid down that where the common law deviates from the spirit, purport and objects of the Bill of Rights, the courts have an obligation to develop the common law in the context of the Section 39(2) objectives. Ignoring the fore stated rule according to Carstens and Kok, would be tantamount to being in breach of the Constitution. That I submit would not be in the interests of the sound administration of justice.

<sup>66</sup> Besides criticizing the judgement of *Strydom v Afrox supra* on Constitutional lines, Carstens and Kok (2003) pages 440 - 449 also criticize the Supreme Court of Appeal in ignoring the judicial resistance given by a number of foreign jurisdictions to disclaimer clauses aimed at exonerating hospitals and other health care providers from liability for medical negligence. To this end the United Kingdom, the United States of America and Federal Republic of Germany have all by way of legislation or case law authority pronounced that the exclusion or limitation of professional medical liability by disclaimer affect the public interest put differently it amounts to an infringement of the boni mores and cannot be upheld. For an in-depth discussion on the foreign law position see Chapter 13.

<sup>67</sup> See also Carstens and Kok (2003) 449 - 452 who argue that medico-legal considerations may also influence the decision making process in deciding on the validity of disclaimer in hospital contracts especially where the process takes place under the influence of a value-driven constitution. In this regard it is especially medical ethics which may bring to bear in pronouncing against the validity of exclusionary clauses. Medical practitioners (and hospitals) by accepting and treating a patient is required to do no harm and to act in the best interest of the patient. Disclaimers against medical negligence in hospital contracts, so it is persuasively argued by Carstens and Kok,

#### 4.5 Performing what was undertaken

The agreement for performance between the doctor and patient is said to also entail that the doctor is expected to perform only that which he had undertaken to do.<sup>68</sup> Unless the doctor expressly guarantees a cure, the patient might be able to claim damages for breach of contract in the event of the doctor failing to fulfil his undertaking. But in the general cause of events the doctor undertakes no more than to treat the patient with the amount of skill, competence and care which may reasonably be expected of practitioners of his branch of medicine.

Likewise, when a patient enters a hospital for treatment and/or confinement and signs an admission form, a contractual relationship between the hospital and patient comes into being. One of the terms of which is the implied term that the hospital and its staff owe the patient a duty to take care.<sup>69</sup> This is where liability in contract, alternatively, in delict

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*"would amount to an unreasonable/unfair/unethical acceptance on the part of the patient to contract to the possibility of harm (in the form of personal injury/death resulting from medical practice) by an attending medical practitioner who is ethically bound not to do harm."* See also Van den Heever "Exclusion of Liability of Private Hospitals in South Africa" *De Rebus*, April 2003 47. The writer criticizes the judgement in that *"..... Not sufficient weight was given to public interests as well as the considerations of public policy."*

<sup>68</sup> Generally a doctor/hospital may not abstain from that what he/she or it has undertaken to do, nor, may the doctor/hospital depart or deviate from the express or implied terms of the agreement. If the doctor/hospital does it will constitute a breach of contract and may result in the doctor/hospital being held liable for patrimonial loss but not for non-pecuniary damages. The doctor/hospital shall also be liable to recover a fee for services rendered. See Van Oosten *Encyclopaedia* (1996) 56; See also Strauss and Strydom (1967) 107; See further Claassen and Verschoor (1992) 116 who are of the view that: *"Where a practitioner digresses from the explicit instructions of a patient, or fails to treat the patient in the manner tacitly agreed upon or explicitly warranted, he will be committing breach of contract and he may be denied the right to recover any remuneration for the services he had rendered."* See also further McQuoid-Mason and Strauss *LAWSA* (1983) 145; *Contra* Gordon, Turner and Price (1953) who opine that besides claiming damages for breach of contract a patient may also repudiate the agreement or seek an interdict depending on the circumstances; See further Dada and McQuoid-Mason (2001) 5 - 6; Strauss and Strydom (1967) 107 also point out that a physician can be delictually responsible where he performs another operation than the one the patient has consented to. Our case law has also recognised the remedies available to a patient where a doctor departs from the patient's express instructions or fails to treat the patient in the manner tacitly agreed upon. In that event 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. See *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). See *Recsei's Estate v Meine* 1943 EDL 277, or a doctor who has undertaken to forward for analysis a biopsy taken of a growth in a patient's nose, through negligence causing the biopsy to be lost. See *Hewat v Rendel* 1925 TPD 679. See further in *Administrator of Natal v Edouard* 1990 (3) SA 581 (A) in which the 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 (sterilization) on a woman who subsequently fell pregnant and gave birth to a child.

<sup>69</sup> In so far as the South African legal position is concerned see generally Strauss (1991) 9; See also Cronje-Retief (2000) 89, 421 who advocates that the duty to take care *"is a strict duty", 'a non-delegable duty' in which the hospital has a primary duty to the patient:*

(i) *to ensure that the duty is performed; and*



(ii) *to be responsible for the manner in which it is performed.*"

See also Van Dokkum "Medical Malpractice in South African Law" *De Rebus* 1996 252 who describe the duty to take care to include:

- deciding whether to undertake the case;
- taking a proper case history;
- making careful diagnosis; and
- properly informing the patient about any proposed treatment or operation and the inherent (material) risks of treatment). A duty of care is similarly imposed when the patient's consent to such treatment is obtained, and in the administration of that treatment or the performance of an operation or medical procedure.

The legal position in England with regard to a hospital's duty of care to its patients is recognised by both academic writers as well as the English courts. See Kennedy and Grubb (1995) describe the duty of care as "*a direct or personal or corporate duty of care.*" See also Brazier (1992) 88 - 89 who state the hospital authorities are "*directly responsible for its own breach of contract*" which is preferred to the term "*direct liability.*" One of the first English cases which dealt with hospital liability and which affected all modern developments of law in this field is the case of *Cassidy v Minister of Health* (1951) 2 KB 343. Denning LJ describes the hospital authorities' duty of care in the treatment of their patients as one purporting "*to involve the use of reasonable care and skill to cure patients of their ailments. He described the duty to use care as follows:*

*"In my opinion authorities who run a hospital, be they local authorities, government boards, or any other corporation, are in law under the selfsame duty as the humblest doctor; whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves: they have no ears to listen through the stethoscope, and no hands to hold the surgeon's knife. They must do it by the staff which they employ, and if their staff is negligent in giving the treatment, they are just as liable for that negligence as is anyone else who employs others to do his duties for him. Once they undertake the task, they come under a duty to use care in the doing of it, and that is so whether they do it for reward or not."* In *Roe v Minister of Health* (1954) 2 QB 66 Denning LJ again had to decide on whether the hospital authority was negligent or not and gave a summary of crucial questions to be answered in every case:

- (i) *The first question in every case is whether there was a duty of care owed to the plaintiff; and the test of duty depends, without doubt on what you should foresee.*
- (ii) *The second question is whether the neglect of duty was a 'cause' of the injury in the proper sense of that term; and causation, as well as duty, often depends on what you should foresee.*
- (iii) *The third question, remoteness of damage, comes into play only when the first two questions - duty and causation - are answered in favour of the plaintiff. The extent of the liability is found by asking: "Is the consequence fairly to be regarded as within the risk created by the negligence?"*

The position in the United States of America is described by academic writers as "*corporate or direct liability arising from a breach of the hospital's independent direct duty of care which it owes the patients.*"

See Cronje-Retief (2000) 354; See also Werthmann *Medical Malpractice Law: How medicine is changing the law* (1984) 19; See also Pozgar *Legal aspects of Health Care Administration* (1993) 207 - 208; See further Mason and McCall-Smith 1987 *Encyclopaedia* 482. According to Pozgar (1993) 207 - 208 "*The direct duties which a corporation owes the general public and its patients, usually arising from statutes, regulations, and principles of law which the courts develop and internal operating rules of the institution.*" In one of the first cases in the United States namely *Darling v Charleston Community Memorial Hospital* 50 Ill APP. 2d 254, 20 NE 2d 149 (1964) AFF 1d 33 Ill 2d 326 211 NE 2d 253 (1969) which formally introduced corporate hospital liability as a legal ground. The court held in determining whether a hospital was negligent the court must start off by looking at "*the duty or standard of care the hospital owed its patients.*" The court held that "*the duty or standard of care contained in the regulations and bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient.*" The court then highlighted the following duties owed by hospital authorities to their patients:

- (i) the duty of nurses to adhere to proper procedures by supervising patients adequately and regularly,
- (ii) the duty that nurses should inform medical staff, the attending physician or the hospital administration of (dangerous) conditions,
- (iii) the duty to obtain the necessary consultation, especially where complications had developed,
- (iv) the duty to review the (independent contractor) physician's work.

In a later judgement of *Gonzales v Work No 228566* (CAL SIP CT Sacramento County) (filed Nov 19, 1973) 1974



sometimes overlaps.<sup>70</sup>

It is especially, from the judgement of the case of *Silver v Premier, Gauteng Provincial Government*<sup>71</sup> that the court refused to distinguish between the tests for causation in considering the contractual, as opposed to the delictual, claim of the patient.<sup>72</sup>

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the court held that the hospital's corporate liability was founded on "its duty to protect patients from malpractice by members of its medical staff." The court held if the hospital knew, had reason to know or should have known that negligent acts were likely to occur, the hospital or the hospital governing basis was corporately responsible for the (negligent) conduct of its medical staff. The North Carolina Court of Appeals in *Boast v Riley* 44 No APP 638, 262 SE 2d SE 2d 391 (1980) recognised the direct hospital duties in the state of North Carolina when it stated: "We acknowledge that a breach of any such duty may correctly be termed corporate negligence, and that our state recognised this as a basis for liability apart and distinct from respondent superior." In this case the court interpreted the hospital's duty to take care to include: "To monitor and overall the physicians prescribing and rendering treatment and medical care at the facility." In a succeeding case of *Johnson v Misericordia Community Hospital* 99 Wis. 2d 708, 301 NW 2d 158 1981 Coffey J recognised that hospitals owe a duty of ordinary care in selecting and maintaining only qualified members on their medical staff, to ensure quality care, diagnosis and treatment of their patients. It was confirmed and concluded that "a hospital is under a duty to execute reasonable care to permit only competent medical doctors the privilege of using their facilities." In the case of *Elam v College Park Hospitals* 4 CIV. No 24479 (CAL.CT APP filed May 27, 1982). The court was also asked to assist the hospital's duty of care towards its patients in employing independent physicians who performed surgery on hospital patients. The court held that the hospital owed a duty of care towards the patients "through careful selection and review, as well as a duty of continuing evaluation to monitor, review and trends in the quality of treatment given by a staff physician over time to ensure quality or adequacy of medical care at the hospitals."

<sup>70</sup> In so far as case law is concerned see *Administrator Natal v Edouard* 1990 (3) SA 581 (A) in which the court found that the hospital liability was established on account of breach of contract in failing to perform the operation they had agreed upon. Van Heerden JA in considering the action state at 588 D-F that: "It was common cause that the respondent suffered damages (i.e. child raising expenses) as a result of the breach, that such damages were a direct and natural consequence thereof, and that the loss was contemplated by the parties as a likely consequence of failure to perform the agreed sterilization operation, more particularly because, to the knowledge of the Administration, the respondent and others could not afford to support any more children. The claim therefore satisfies all the requirements of our law for the recovery of damages flowing from breach of contract." See also the case of *Silver v Premier, Gauteng Provincial Government*, 1998 (4) SA 569 (W); per Cloete J at 574 J-575 B: The plaintiff's claim was 'founded in contract and, in the alternative, in delict. ... The loss sustained by the plaintiff is said to have been caused by the breach of an implied term of an agreement that the hospital through its staff and employees would exercise due care, skill and diligence in providing nursing care. Precisely the same facts are relied upon as constituting a breach of the implied term of the duty of care owed to the plaintiff.' The latter 'duty of care' (formulation) referred to, could also have founded another alternative/sovereign legal ground for hospital liability delictual liability. The court stated further that as the plaintiff's claim was founded in contract and, in the alternative in delict, there was no reason why the *sine qua non* test should not apply equally to the contractual claim *in casu*. It was also been emphasized that common sense must be employed in such cases (at p574-575) of the judgement. This approach has also been emphasized by Corbett JA in the case of *Siman and Co (Pty) Ltd v Barclays National Bank Ltd* 1984 (2) SA 888 (A) 914F-915A; *International Shipping Co (Pty) Ltd v Bentley* 1990 (1) SA 680 (A) 700E-701F.

<sup>71</sup> 1998 (4) SA 569 (W).

<sup>72</sup> For a comprehensive discussion on the potential convergence of the principles of the law of contract and the delict see Carstens and Pearmain (2007) 511ff. The writers argue that this is particularly relevant in the context of claims involving healthcare services since the facts upon which the claim is based, whether in contract or delict, are much the same in many instances. See Page 511 of the Judgement.

## 4.6 FORMALITIES TO COMPLY WITH

### 4.6.1 Legal Writings

The agreement between doctor/hospital/other healthcare provider and patient require no legal formalities to bring about a valid contract.<sup>73</sup>

In practice the terms of the agreement between the doctor and patient are rarely written down or even expressly discussed. Consensus has been reached amongst our legal writers that where no legal forms are required the agreement generally comes into existence by mere consensus.<sup>74</sup>

Where a patient, however, is admitted to a hospital or clinic, the agreement between the hospital/clinic and patient, is usually reduced to writing, in that, the patient is required to sign an admission form, which also serves as a consent form and which sets out, *inter alia*, the type of treatment or operation which the hospital/doctor/clinic will undertake.<sup>75</sup>

What is required however, to bring about a valid contract, as will be seen hereinafter is the pre-consensus phase of offer and acceptance.

#### 4.6.1.1 Case Law

The only case I came across during my research which dealt with the formalities which

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<sup>73</sup> See Van Oosten (1996) 54 who acknowledges that due to the very nature of the doctor/hospital/patient relationship the contract may be express or tacit, written or oral hence no legal formalities are required for the conclusion of the contract between the doctor/hospital/patient. See also Strauss and Strydom (1967) 105; See further Claassen and Verschoor (1992) 115; See further Gordon Turner and Price (1953) 70.

<sup>74</sup> See Strauss and Strydom (1967) 105 - The consensus between the parties are reached by way of an offer and acceptance which are either orally agreed to or may be inferred from their conduct. See also Gordon, Turner and Price (1953) 78; Van Oosten (1996) 54; Claassen and Verschoor 115; McQuoid-Mason and Strauss *LAWSA* (1983) Par 189. See also Strauss and Strydom (1967) 105 - They emphasize especially with more serious operations, written agreements serve an important purpose in that, it highlights the nature of the operation and the functions of the practitioner. They also serve to provide proof of the agreement between the practitioner/hospital/clinic and patient in a civil trial. See further McQuoid-Mason and Strauss *LAWSA* (1983) Vol. 17 144 who emphasize the importance of reducing unusual procedures to paper particularly where informed consent of the patient is required; Strauss (1991) 9-10 who cautions that the contents of the admission form should be explained to the patient in order to obtain real consent otherwise such consent "*would have been expressed in form only, not in reality.*" The author sounds the following advice: "*The consent given by a patient on the admission form should be reasonable specific and comprehensive*" in order to escape such consent from being "*ruled invalid by our courts on account of vagueness*". For what are usually included in typical admission forms the appendices may be consulted.

<sup>75</sup> See Van Oosten *Encyclopaedia* (1996) 54. Hospitals, irrespective of whether they run privately or by the State, usually require from their patients the signing of an admission form.

ought to be complied with in a medical setting, is that of *Myers v Abrahamson*.<sup>76</sup>

#### 4.6.1.2 OFFER AND ACCEPTANCE

The pre-consensus phase of offer and acceptance in the medical contract context is as essential as that which was described in the foundation of a contract in general. It is submitted, that the origin of a contractual commitment is the initial suggestion of willingness to enter into a contract.

Therefore an offer is a communication that creates the possibility of the foundation of a contract between the doctor/hospital and the patient. If the offer is accepted a contract between them comes into being. As disputes may arise over whether there was an offer or not, it is critical to establish whether an offer was made or not.

The criteria for one to establish whether an offer was made, has been said, in law, to be a very practical one.<sup>77</sup> The terms of the offer must be sufficiently firm to allow court enforcement.

Equally important is to establish that the offer was accepted before any court will enforce a contract. There must be some act manifesting assent and willingness to be bound by the terms of the contract.

It has also been suggested before that the acceptance must be made in response to, or at least with knowledge of, the offer.<sup>78</sup> In other words, the acceptance has to be unequivocal.

#### 4.6.1.3 Legal Writings

Although, as was seen hereinbefore, the coming into existence of a contract between the doctor and patient is critical, there is little guidance to be found in South African legal writings as to when the contract is formed, our legal writers are however of the view that,

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<sup>76</sup> 1951 (3) SA 438 The court in this matter held: *"Unlike for example the Land Alienation Act or the Credit Agreement Act in terms of which, the parties are required to reduce their agreement to writing, and although as previously stated, the agreement between the doctor and patient being a consensual one, the law does not require the doctor and patient to go about it as though they are drawing up a deed of sale."*

<sup>77</sup> See Hutchinson Van Heerden Visser and Van der Merwe *Wille's Principles of South African Law* 3ed (1991) 412. The authors' state that the determination can be made by establishing what was said if the offer was made orally or in writing alternatively by looking at the conduct of the parties alone, where no words are spoken or reduced to writing. See also Kerr 5ed (1988) 4; Christie 3ed (2006) 2.

<sup>78</sup> See Hutchinson et al (1981) 412ff; See also Kerr (1998) 7; Christie (1996) 6.

akin to the formation of any contract outside the field of medicine, there must be an offer and acceptance together with consideration, before one can say that the doctor/hospital/other health-care provider and patient has reached agreement or otherwise known as *consensus*.<sup>79</sup>

#### 4.6.1.4 Case Law

Equally the South African case law pertaining to the principle of offer and acceptance in medical context is very rare. The only case I came across during my research which deals with conditional acceptance is the case of *Sutherland v White*<sup>80</sup> in which a dentist supplied a set of dentures to a patient. After receiving the set of dentures the patient complained that the dentures did not fit properly. The patient refused to pay the dentist for services rendered and the dentist subsequently sued the patient for his fees.

#### 4.6.2 Terms of the Agreement

It is of the utmost importance in the formation of a contract generally, that the parties to the agreement come into conscious accord,<sup>81</sup> before it can be said that, a valid agreement had come into being.

One of the means of coming into conscious accord, it is submitted, is to create clear and unequivocal terms especially where express terms are created.<sup>82</sup>

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<sup>79</sup> See Strauss and Strydom 1967) 105 - The authors recognize that although offer and acceptance may take place orally or by mere conduct between the parties it is sometimes however uncertain who in the doctor/hospital-patient relationship acts as the offeror and likewise, who acts as offeree. The authors suggest that where a patient summons a doctor or consults a doctor and consents to be examined and/or treated, such conduct amounts to an offer whereas the conduct of the doctor when accepting such an offer amounts to acceptance. See also Gordon Turner and Price (1953) 78 - The authors are of the view: "*The contract to treat a patient begins from the moment that the practitioner accepts the case, expressly or impliedly.*" See also McQuoid-Mason and Strauss LAWSA (1983) Par 189 who suggest further that where a patient goes to hospital for medical treatment by hospital staff, a contract arises between him or her and the hospital authority.

<sup>80</sup> 1911 E.D.C. 407 it appears from the dictum that the dentist by undertaking to supply the patient with 'proper and usable set of teeth' constituted an offer and 'the patient's willingness to accept such dentures' an acceptance.

<sup>81</sup> See Joubert Harms Rabie LAWSA Volume 5 Part 1 (1994) 188.

<sup>82</sup> See Joubert Harms Rabie LAWSA (1994) 189; The authors endorse the principle laid down by Innes JA in *Pieters and Co v Solomon* 1911 AD 121 at 137 - 138: "*When a man makes an offer in plain and unambiguous language, which is understood in its ordinary sense by the person to whom it is addressed, and accepted by him bona fide in that sense, then there is a concluded contract. The promisor is bound to perform what his language justified the promisee in expecting. Cf also the well-known dictum of Blackburn J in Smith v Hughes (1871) 6 OB 597 607: "If, wherever a man's real intention may be, he so conducts himself that a reasonable man would believe that he was assenting to the terms proposed by the other party, and that other party upon that belief enters into the*

But even where the offer creates clear and unequivocal terms, the conscious accord may adversely be affected where the offeree is faced with a case of offers to the general public which are embodied in the self-evident proposition that is impossible for a person to accept an offer of which he or she is unable,<sup>83</sup> or where the validity of a contract may be affected by mistake, (error)<sup>84</sup> misrepresentation,<sup>85</sup> duress,<sup>86</sup> the contract as a whole being against

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*contract with him, the man thus conducting himself would be equally bound as if he had intended to agree to the other party's terms*", often cited with approval by SA courts: See *Van Rhyn Wine and Spirit Co v Chandes Bar* 1928 TPD 417 423; *Hodgson Bros v SA Railways* 1928 CPD 257 261; *Collen v Rietfontein Engineering Works* 1948 1 SA 413 (AO 429 - 430); *Ocean Cargo Line Ltd v FR Waring (Pty) Ltd* 1963 4 SA 641 (A) 653; *Spes Bona Bank Ltd v Portals Water Treatment SA (Pty) Ltd* 1983 1 SA 978 (A) 984E-F; See also *Sonop Petroleum (SA) (Pty) Ltd (formerly known as Sonarep (SA) (Pty) Ltd v Pappadogiannis* 1992 SA 234 (A). The above principle is advocated by the authors Joubert Harms Rabie LAWSA (1994) Vol. 5 Part 1 190 in that the authors suggest that unless the offer is not couched in definite and complete terms which embodies sufficient information in which a clear indication of the offeror's intention, acceptance thereof cannot give rise to a contract. See also the following South African case law: *Humphreys v Cassell* 1923 TPD 280; *Regenstein v Brabro Investments (Pty) Ltd* 1959 3 SA 176 (FC). In such cases it is usually said that the "contract is void for vagueness." See, further, on the subject of vagueness, *Williams and Taylor v Hitchcock* 1915 WLD 51; *Strand Meat Co (Pty) Ltd v Smith* 1930 CPD 24; *Mouton v Hanekom* 1959 3 SA 35 (A); *Kantor v Kantor* 1962 3 SA 207 (T). See also *Spes Bona Bank Ltd v Portals Water Treatment SA (Pty) Ltd* 1983 1 SA 978 (A) in which an invoice was held not to constitute an unequivocal offer to sell. Cf *Saambou Nasionale Bouvereniging v Friedman* 1979 3 SA 978 (A).

<sup>83</sup> See Christie (2006) 32ff; Lubbe and Murray (1988); Joubert et al (1994) 194. See also the case law *Bloom v The American Swiss Watch Co* 1915 AD 100.

<sup>84</sup> See Joubert Harms Rabie LAWSA (1994) Vol. 5 Part 1196. The authors advocate that the validity of a contract "may be affected by mistake (error) in that the offence may either be under a wrong impression regarding some fact connected with the contract" or "each party is mistaken as to the other's intention and the parties are consequently at cross-purposes." This is sometimes referred to as "mutual mistake" in which both parties are under the wrong impression. On the other hand, so it is advocated by Joubert Harms Rabie LAWSA (1994) 197 - 198 it may also happen that one of the parties is under a mistaken belief also termed "unilateral mistake" as a result of which he is allowed to claim nullity of a contract on the grounds of mistake, provided "he shows that he was labouring under a mistake which was both operative and reasonable often referred to as a justus error." See also the following South African cases: *Logan v Beit* (1890) 7 SC 197; *Maritz v Pratley* (1894) 11 SC 345; *George v Fairmead (Pty) Ltd* 1958 2 SA 465 (A); *National and Overseas Distributors Corporation (Pty) Ltd v Potato Board supra*; *Van Wyk v Otten* 1963 1 SA 415 (O); *Allen v Sixteen Stirling Investments (Pty) Ltd* 1974 4 SA 164 (D); *Gollach and Comperts (1967) (Pty) Ltd v Universal Mills and Produce Co (Pty) Ltd* 1978 1 SA 914 (A); *Papadopoulos v Trans-State Properties and Investments Ltd* 1979 1 SA 682 (W); *Glen Comeragh (Pty) Ltd v Colibri (Pty) Ltd v Interior Acoustics (Pty) Ltd* 1984 3 SA 537 (W); *Kempston Hire (Pty) Ltd v Snyman* 1988 4 SA 465 (T).

<sup>85</sup> See Christie (2006) 871ff; Joubert et al (1994) 201. The authors state that in certain instances an agreement can be nullified because of one or another form of misrepresentation. "A party who has been persuaded by a misrepresentation to enter into a contract or to agree to terms to which he would not otherwise have agreed, is entitled to relief whether the misrepresentation was fraudulent (intentional), negligent or innocent." But argues the author: "The nature of the relief differs, however, according to whether the misrepresentation was fraudulent or not."

<sup>86</sup> See Christie (2006) 301ff; Joubert et al (1994) 207ff who comments as follows on the effect of duress and undue influence: "If a person consent to a contract is obtained by some form of pressure which the law regards as improper, the contract is voidable at the instance of the person thus imposed upon. There are two forms of pressure which the law regards as improper, duress and undue influence." The authors emphasize that this occurs particularly in instances where a special relationship exists *inter alia*, "a doctor and patient relationship."

public policy.<sup>87</sup>

#### 4.6.2.1 Actual Terms of the Agreement

##### 4.6.2.1.1 Legal Writings

The terms of the agreement as between the doctor/hospital/clinic and patient, as stated hereunto fore, may either be implied or expressed or in certain circumstances expressed and implied. Generally, in the absence of an express agreement between doctor/hospital/clinic and patient and depending on the circumstances, implied terms emerge,<sup>88</sup> the nature whereof will be discussed hereinafter.

##### 4.6.2.2 Implied Terms

One of the most fundamental terms of the agreement between the doctor/hospital/other healthcare provider and patient is that the doctor/hospital/other healthcare provider, when accepting and commencing treatment and/or executing surgery, he, she or it undertakes to exercise reasonable care and skill in treating and/or operating on the patient.<sup>89</sup> This undertaking to treat does not, however, entail that a doctor/hospital guarantee that the patient will be healed of his or her ailment or cured of his or her disease, unless the doctor expressly guarantees the result.<sup>90</sup>

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See further the South African case of *Preller v Jordaan* 1956 (1) SA 483(A) in which the court found that undue influence prevented true consent and subsequently denied *restitutio in integrum*.

<sup>87</sup> See Christie (2006) 337ff; Joubert et al (1996) 214-215. The authors state that notwithstanding agreement being reached between the parties to the contract, in instances "*when its conclusion, its performance or its object is expressly or impliedly prohibited by legislative enactment or is contrary to good morals or public policy,*" the contract is illegal and void. The authors identify "*freedom of contract on the one hand balanced by the necessity to do simple justice between man and man, as a constituent of public policy.*" But cautions the authors "*the power to declare a contract contrary to public policy should be exercised sparingly and only when the impropriety of the contract and the element of public harm are manifest.*" See also *Botha (now Griessel) v Finance Credit (Pty) Ltd* 1989 3 SA 773 (A) 782i - 783c.

<sup>88</sup> See Van Oosten *Encyclopaedia* (1996) 54; See also Strauss and Strydom (1967) 105; See also Gordon Turner and Price (1953) 75ff; See further Claassen and Verschoor (1992) 115; McQuoid-Mason and Strauss *LAWSA* (1983) Par 144; Van Dokkum (1996) 256.

<sup>89</sup> See Van Oosten (1996) 54. The author describes the nature of this implied term as an undertaking "*to examine the patient and/or diagnose his or her ailment and/or treat his or her condition with such professional care, skill and judgement as the average or ordinary medical practitioner in the particular branch of the profession possesses, and in accordance with the recognised, accepted, customary or usual practices of medicine.*" See also Claassen and Verschoor (1992) 115 - 116; Strauss and Strydom (1967) 106; Strauss (1984) 37; McQuoid-Mason and Strauss *LAWSA* (1983) Par 144.

<sup>90</sup> See Van Oosten *Encyclopaedia* (1996) 55; See also Strauss and Strydom (1967) 106 - 107; See further Claassen and Verschoor (1992) 116 - "*Although a physician is free, however to warrant explicitly that he will cure a patient, in which he will expose himself to a claim for damages based on breach of contract should he be unable*



The implied term to exercise due care and skill has its origin in the common law<sup>91</sup> and is also governed by legislation.<sup>92</sup> It has its roots, so it is submitted, in the fiduciary relationship between the doctor/hospital and patient, in which, the doctor/hospital is expected to exercise their professional skills with the utmost diligence, in which the patient's interests are placed first in accordance with the time-honoured traditions of service, duty, and honour.<sup>93</sup> It is against this background that the focal point of this research will be conducted, in establishing whether exemption clauses contained in hospital admission forms, in an attempt to exempt hospitals from liability where a patient is injured or suffered loss or damage arising from the negligent conduct of the hospital or its staff, are valid or not! In other words, can the patient, who is a party to a contractual agreement, exempt the hospital from liability where the hospital or their staff fails in their duty to exercise due care and skill? Alternatively, does an attempt by a hospital to exclude the exercise of due care and skill, by incorporating exemption clauses in hospital admission forms, constitute acceptable conduct?

#### 4.6.2.3 Expressed Terms

##### 4.6.2.3.1 Legal Writings

From what was discussed *supra* and as a general rule, the contract entered into between the doctor and patient, takes the form of a tacit agreement which includes implied terms of which the doctor's duty to take care is possibly the most important. On the other hand, particularly where the doctor adopts an unusual procedure or in the event of a patient being hospitalized, the agreement between the doctor/hospital and patient is usually reduced to writing, containing the express terms agreed upon amongst the parties themselves, *inter alia*, what treatment is to be given, the procedure to be followed where corrective surgery is indicated.<sup>94</sup>

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*to fulfil his undertaking.*" See also McQuoid-Mason and Strauss *LAWSA* (1983) 144; See also Dada and McQuoid-Mason (2001) 5 *Contra* Strauss (1991) 37. The author cautions "*it would be unwise for a prudent doctor to guarantee such results.*"

<sup>91</sup> See Strauss and Strydom (1967) 111; The authors reason that such an implied term is founded in the nature of the profession of the doctor in which, the doctor is seen to stand in a position of trust with his or her patient in which, the doctor undertakes to execute his or her duties with the necessary good faith and with the utmost care and skill. See also De Wet and Yeats (1978) 308; See also Claassen and Verschoor (1992) 116; See also Van der Merwe and Olivier (1989) 84ff; See also McKerron *The Law of Delict* (1971) 38; See also Van der Walt and Midgely *Delict: Principles and Cases* (1997) 73.

<sup>92</sup> See Strauss (1984) 437-441; See also *The Prisons Act* 8 of 1959.

<sup>93</sup> See a detailed discussion in Chapter 5 *infra*.

<sup>94</sup> See McQuoid-Mason and Strauss 17 *LAWSA* (1983) 144 - 145; Van Oosten *Encyclopaedia* (1996) 54 - 55; Strauss and Strydom (1967) 104 - 110; Strauss (1991) 8 - 10; Gordon Turner and Price (1953) 75 - 78.

Where the procedure has to be carried out by someone else, the name of the specialist concerned, the means of payment etc must be reduced to writing.<sup>95</sup> Typical agreements, containing express terms entered into between hospital/other healthcare providers and patient, are often found in hospital admission forms incorporating consent forms, as well as consent forms generally used by clinics.

Although the doctor and patient have the utmost freedom to contract and generally wide latitude is allowed in their selection of express terms,<sup>96</sup> it is submitted that there are limits to what the parties may purport to agree through express terms. They cannot, for example, agree to do that which would be regarded as contrary to public policy.<sup>97</sup>

It is for this purpose that the research undertaken attempts to establish whether an exculpatory clause contained in a hospital admission form, indemnifying a hospital against any negligence, form part of the limits referred to. In order, ultimately, to make such a finding, it is of the utmost importance to look briefly also at the patient's consent, the different forms of consent and the restrictions on consent, etc.

#### 4.6.2.3.2 Case Law

Some courts have repeatedly confirmed that the terms of the agreement between the doctor/hospital and patient may either be implied or expressed or, in certain instances, expressed and implied.

One of the earliest cases dealing with the implied terms of the agreement between the doctor and patient is that of *Kovalsky v Krige*,<sup>98</sup> in which the Plaintiff, an infant, was duly assisted by his father and natural guardian. The Plaintiff's declaration also contained the following facts namely:

In accordance with the Jewish custom, plaintiff was submitted, in November, 1909, to the

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<sup>95</sup> See Strauss (1991) 8 - 10 The author highlights the necessity and advantages of reducing express terms into writing in that medical treatment `entails a certain amount of risk' and notwithstanding the inherent risk attached to such treatment and with the patient `adequately apprised of the risks involved', where the patient nonetheless, consents to such `drastic or unusual treatment', written consent containing the expressed terms, will provide proof of such informed consent and is of the utmost importance in safeguarding the doctor against unwarranted legal proceedings.

<sup>96</sup> See Van Oosten (1996) 57.

<sup>97</sup> See Van Oosten (1996) 88; See also Strauss and Strydom (1967) 110, 324. See also Strauss (1991) footnote 43 at 349. See further Van Dokkum (1996) 255; See further Cronje-Retief (2000) 440 et seq.

<sup>98</sup> 1910 20 CTR 822.

operation of circumcision. This was performed by the Ref E Lyons. Afterwards the child suffered from haemorrhage, and defendant was called in. He prescribed certain treatment, which was carried out. Subsequently gangrene developed, and the child sustained certain permanent injuries. It was alleged that these were due to the unskilful, negligent, and improper treatment of the defendant. Plaintiff claimed 500 pounds damages.

Buchanan J referring to the English decision of *Lampher v Phipos*<sup>99</sup> agrees with the principle laid down therein namely:

*"Every person who enters into a learned profession undertakes to bring to it the exercise of a reasonable care and skill. Speaking of a surgeon, he says he does not undertake that he will perform a cure, nor does he undertake to use the highest possible degree of skill. He undertakes to bring a fair, reasonable and competent degree of skill to his case."*

In a later decision of *Coppen v Impey*,<sup>100</sup> the plaintiff sought to recover damages from the defendant, a medical practitioner, who treated her for rheumatism. Her case is that, while suffering from rheumatism in the back of the right hand, she went to the defendant for treatment with the X-rays. She complains that, while under the defendant's care, the condition of her hand became worse, causing her great pain and suffering, and she attributes this to the negligent, unskilful and improper treatment of her hand by the defendant, or his assistant, or both, in the application of the X-Rays.

Kotze J in assessing the implied duty of the medical practitioner made the following remarks: *"For holding himself out as a professional man, he undertakes to perform the service required of him with reasonable skill and ability."*

But, cautions the court, by undertaking to perform the services required of him: *"He does not undertake to perform a cure, or to treat his patient with the utmost skill and competency, he will, on the other hand be liable for negligence or unskilful ness in his treatment."*<sup>101</sup>

In another South African decision *Mitchell v Dixon*,<sup>102</sup> the Appellate Division, the Plaintiff

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<sup>99</sup> (1835) 8 C and 475.

<sup>100</sup> 1916 CPA 309.

<sup>101</sup> *Coppen v Impey* 1916 CPA 309 at 314.

<sup>102</sup> 1914 AD 519.

sought to have the court hold a doctor liable for injuries caused to the patient by the breaking of the needle of a syringe used during exploration of the chest cavity for suspected pneumo-thorax. The court in stressing that medicine is not an exact science and even a specialist is not infallible, formulates the implied duty of the medical practitioner as:

*"A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not."* <sup>103</sup>

In a later Appellate division case of *Van Wyk v Lewis*, <sup>104</sup> regarded by many as the *locus classicus*, the court was asked to adjudicate on the conduct of a medical practitioner, who, having performed an emergency abdominal operation upon the plaintiff left a swab in her body. Some twelve months later the plaintiff evacuated the swab through her bowel, into which it had evidently found its way. Alleging that the defendant had acted negligently and unskilfully in failing to remove the swab, the plaintiff sued him for 20000 Pounds damages.

Innes CJ recognises the implied contractual term between the medical practitioner and patient when commenting: *"No doubt the duty to take care arose from the contractual relationship between the parties, but it was a duty the breach of which was actionable under the Aquilian procedure. The Respondent's liability therefore depends on whether it was due to negligence or unskilfulness on his part that the swab was allowed to remain in the wound."* <sup>105</sup>

As to the nature of the duty to take care and endorsing the principle laid down in *Mitchell v Dixon* <sup>106</sup> namely the medical practitioner is expected to employ 'reasonable skill and care'. Lewis CJ continues to state:

*"And in deciding what is reasonable the court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs."* <sup>107</sup>

Wessels JA delivering a concurring judgement gives a more informative account of the implied term of the contractual agreement between the medical practitioner and patient

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<sup>103</sup> *Mitchell v Dixon* 1914 AD 519 at 525.

<sup>104</sup> 1924 AD 438.

<sup>105</sup> *Van Wyk v Lewis* 1924 AD 438 at 444.

<sup>106</sup> 1914 AD 519 at 525.

<sup>107</sup> *Van Wyk v Lewis* 1924 AD 438 at 443.

when he states:

*"The case is one of those where the relationship between the parties arises out of a contract but where the act complained of is an injury or delict done in consequence of carrying out the contract. The delict grows out of a breach of duty which the law implies from the contract between the parties, the duty of the surgeon, who contracts to operate, not to do so negligently. I think the law necessary for the decision of this case may well be stated in a series of propositions."* <sup>108</sup>

Wessels JA continued to formulate a series of propositions *inter alia*:

*"(1) The contract between a patient operated upon in a hospital and the operating surgeon is that the surgeon will perform the operation with such technical skill as the average medical practitioner in South Africa possesses and that he will apply that skill with reasonable care and judgement. [A] medical practitioner is not expected to bring to bear the highest possible professional skill but is bound to employ reasonable skill and care. It seems to me, however, that you cannot expect the same skill and care of a practitioner in a country town as you can of one in a large hospital. You can only expect of surgeons in South Africa that degree of skill and that degree of care which is generally to be found in surgeons practising in this country. 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 judgement have been exercised."* <sup>109</sup>

In a later case of *Buls v Tsatsarolakis* <sup>110</sup> the Plaintiff sued the doctor after the Plaintiff was treated at a Provincial Hospital for a painful wrist. The facts relied on can briefly be summarized as follows:

Although the wrist was X-rayed, Dr B could detect no fracture, nor did the radiologist who subsequently reported on the X-rays, find any. The Plaintiff's wrist was strapped with Elastoplasts, he was given tablets to reduce the swelling and relieve the pain, and he was told to return a week later. When the Plaintiff duly returned the pain had diminished and the swelling had almost disappeared. Dr B gave him further medication and told him to return again if the pain continued. The pain did continue, but the Plaintiff did not return. Three weeks after the accident he consulted a specialist orthopaedic surgeon, who, after further X-rays had been taken, diagnosed a fracture of the scaphoid bone of the Plaintiff's right wrist, and immobilized the wrist in plaster for a time. Alleging that, as a result of Dr B's negligence and lack of skill (of which he gave full particulars), the proper treatment of his wrist had been delayed for three weeks, the Plaintiff sued Dr B and the Administrator of the Transvaal as first and second defendants respectively. He claimed damages for pain and

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<sup>108</sup> *Van Wyk v Lewis* 1924 AD 438 at 455-456.

<sup>109</sup> *Van Wyk v Lewis* 1924 AD 438 at 457.

<sup>110</sup> 1976 (2) SA 891 (T).

suffering and loss of earnings for three weeks, together with the specialist's fee and the cost of the X-rays ordered by him, a total of R779.30.

Recognising the medical practitioner's duty to act in terms of the implied term of the agreement the court of appeal held:

*"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?"*<sup>111</sup>

*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? It is an interesting question but, because it was not argued and because it is not necessary for the purposes of the present decision to answer it, I shall not discuss it further."*<sup>111</sup>

As to the standard of care required of a medical practitioner, the court contended:

*"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. (See Mitchell v Dixon 1914 AD 519)."*<sup>112</sup>

In a later decision of *Pringle v Administrator, Transvaal*<sup>113</sup> the court had to consider the following facts in deciding whether the defendant, the *Administrator, Transvaal* was negligent or not.

The plaintiff presented at a Transvaal Provincial Administration hospital with a past history of chest carcinoma and opacity (shadows) on the lung. A biopsy of a Para tracheal node was indicated. The procedure adopted (correctly) by the surgeon was a mediastinoscopy, a minor procedure but an invasive one. That is, incision into the mediastinum or area between the lungs and heart, which would facilitate the removal and biopsy of a lymph node on the trachea. In the course of removal of the Para tracheal node, the superior vena cava was perforated, by what the surgeon himself conceded was the use of 'excessive force' in excising the node; the resultant haemorrhage from the superior vena cava was not diagnosed until, after leaving the theatre, the patient became hypertensive. The surgeon waited in the recovery room with her, monitoring her condition, whilst X-rays were taken to

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<sup>111</sup> *Buls v Tsatsarolakes* 1976 (2) 891 (T) at 893.

<sup>112</sup> *Buls v Tsatsarolakes* 1976 (2) 891 (T) 894.

<sup>113</sup> 1990 (2) SA 379 (W).



establish whether or not bleeding from the superior vena cava was the cause of hypotension. Thereafter the patient was returned to theatre for emergency surgery. This latter surgery commenced some one hour fifteen minutes after the mediastinoscopy had been completed. A partial thoracotomy (opening of the chest) revealed that an estimated two litres of blood (approximately one-third of the total blood volume) had escaped through a tear in the superior vena cava and mediastinal pleura, and accumulated in the pleural cavity. The vessel was repaired, but as a result of the perforation and blood loss the plaintiff suffered an occipital lobe thrombosis, that is, a blood clot in the posterior area of the brain. The resultant damage to the brain led to substantially impaired eyesight and a permanent inability to continue in her employment.

The plaintiff subsequently sued the hospital for damages arising from the hospital's alleged negligence. The court consequently found for the plaintiff and recognised the hospital's duty of care towards the plaintiff which, by implication, the court found to be an implied term of the agreement between the hospital and patient. Consequently, the sole ground on which the court found for the plaintiff was that the surgeon had been negligent in perforating the superior vena cava. The principle on which the court based its finding was that negligence is the failure of a medical professional to achieve the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which he belongs (per Innes ACJ) in *Mitchell v Dixon* 1914 AD 519 at 525).

In a later judgment of *Friedman v Glicksman*<sup>114</sup> the court was also confronted with the question; whether a breach of the implied terms of the agreement between hospital and patient occurred. The facts relied upon by the plaintiff can briefly be stated as follows:

The plaintiff alleged that his disability had resulted from infection which had entered and spread from a sacral bedsore, which he had sustained in consequence of the negligent omission on the part of the nursing staff to apply proper care while he was in the general surgical ward of the hospital before being admitted to the intensive care unit (ICU).

Cloete J who delivered the judgement stated *inter alia*:

*"I am aware that the plaintiff's claim is founded in contract and, in the alternative, in delict. But I see no reason why the sine qua non test should not apply equally to the contractual claim in casu. The loss sustained by the plaintiff is said to have been caused by the breach of an implied term of an agreement that the hospital through its staff and employees would exercise due care, skill and diligence in providing nursing care. Precisely the same facts are relied upon as constituting a breach of the implied term as are relied upon as constituting a breach of the duty of care owed to the plaintiff. It would be anomalous if the same result did not follow irrespective of the cause of*

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<sup>114</sup> 1998 (1) SA 569 (W).

action. Furthermore, although the question of remoteness of damage for breach of contract is approached (in the absence of a contractual stipulation as to the basis on which compensation is to be made) by determining whether the damage flowed naturally and directly from the defendant's breach or is such a loss as the parties contemplated might occur as a result of such breach." <sup>115</sup>

#### 4.6.2.4 Clear and Unequivocal Terms

Equally important in the legal relationship between doctor and patient, especially where Consent, is required, it is important to ensure from a medical practitioner/hospital's point of view, that clear, unequivocal and comprehensive consent is obtained from the patient. This, it is submitted, is only attainable if the patient is given clear and unequivocal terms to consider before he or she finally concludes the agreement. Where the medical treatment involves a certain amount of risk not only is it essential to adequately apprise the patient of the risks in clear and unequivocal terms, it is also of the utmost importance to ensure that the patient clearly understands the risks involved and that he or she is prepared to undergo the suggested treatment notwithstanding the risks involved. <sup>116</sup>

#### 4.6.3 The Patient's Consent

The patient's consent for a number of reasons is of paramount importance within the Doctor/hospital/other health-care provider and patient contractual relationship. <sup>117</sup>

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<sup>115</sup> *Friedman v Glicksman* 1998 (4) SA 569 (W) at 573-574

<sup>116</sup> See Strauss (1991) 8. The author suggests that to safeguard a doctor against unwarranted legal proceedings, "it may be to the advantage of the doctor to take a written and signed consent in which the nature of the treatment is described in detail especially where the treatment is very drastic or unusual." Of similar import for the medical practitioner to obtain unequivocal consent is in a situation where certain conditions are imposed by the patient especially where the patient is one of those difficult patients. It is of the utmost importance to agree on clear and unequivocal terms before the doctor commences treatment. See Strauss (1991) 9. See further Strauss (1991) 9-10 who suggests where the hospital makes use of admission forms which also serves as a consent form in which the type of treatment or operation which will be undertaken, the hospital authorities will be well advised to formulate the consent required from the patient "as reasonably specific and comprehensive as possible setting out all the risks applicable where possible by competent staff who ensure that the patient clearly understands the contents and unequivocal consent thereto."

<sup>117</sup> Our legal writers on a number of occasions have expressed their opinion namely: "Consent between the doctor/hospital/other health care provider and patient is one of the material manifestations of the existence of consensus ad idem, the latter being a prerequisite for a healthy contractual relationship." See Van Olsten *Encyclopaedia* (1996) 63. See also Strauss (1991) 91; See further Strauss and Strydom (1967) 106. It is particularly in medical interventions or where the medical treatment is very drastic or unusual that Van Oosten *Encyclopaedia* (1996) 63 states: "The patient's effective consent is fundamental." See also Strauss (1991) 91; See further Strauss and Strydom (1967) 106. Another of the reasons advanced is that a patient has an absolute common law and constitutional right to his or her integrity and security. For the common law position see the legal writings of Van Oosten *Encyclopaedia* (1996) 64; Strauss (1991) 4; Gordon Turner and Price (1953) 153; Dada and McQuoid-Mason (2001) 7; For the South African case law see *Stoffberg v Elliot* (1923) 148; *Lambert v Hefer* 1955 (2) SA 507 (a) 508; *Esterhuizen v Administrator Transvaal* (1957) 718; *S v Sikunyana* 1961 (3) SA 549 at 551; *Richter and Another v Hamman* (1976) 232; *Burger v Administrateur Kaap* 1990 (1) SA 483 (C); *S v Kiti* 1994 (1) SACR 14 (E) at 18; *S v Binta* 1993 (2) SACR 553 (C) at 561 - 562. For the Constitutional Law position see S12(1)and(2) of the *Constitution of the Republic of South Africa Act* 108 of 1996 which reads as follows:

It is against this background that an investigative study will be made in regard to the validity of the so-called "*contracting out of liability*" clauses, alternatively indemnity clauses (also known as exculpatory clauses), in which the doctor or hospital purport to contract out of liability for malpractice.

#### 4.6.3.1 Forms of Consent

Consent, regardless of whether entered into between a doctor and patient or hospital/other health care provider and patient, may be granted expressly, <sup>118</sup> either orally <sup>119</sup> or in writing,

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"Freedom and security of the person" 12(1) Everyone has the right to freedom and security of the person, which includes the right-

- (a) not to be deprived of freedom arbitrarily or without just cause;
  - (b) not to be detained without trial;
  - (c) to be free from all forms of violence from either public or private sources;
  - (d) not to be tortured in any way; and
  - (e) not to be treated or punished in a cruel, inhuman or degrading way
- (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."

Consent it is submitted may also be an important element where a doctor or hospital attempts to successfully plead in an action for assault and false imprisonment the defence of '*volenti non fit injuria*'. For the defence of *volenti non fit injuria* to be successful however, the following requirements have to be met namely: Firstly, the patient must have knowledge of the procedure to be followed, as well as, the nature or extent of the harm or risk. Secondly, the patient must appreciate and understand the nature of the harm or risk and notwithstanding, consents to the harm or assumed the risk. Thirdly, the consent given must be comprehensive and extend to the entire transaction inclusive of its consequences. Further, the act consented to must be in accordance with public policy, and not *contra bonos mores*. For the comments of the legal authors see Van Oosten (1996) 63, 73, 76, 77 - 78; See also Gordon, Turner and Price (1957) 162; See further Strauss and Strydom (1967) 237; McQuoid-Mason and Strauss *LAWSA* (1983) P198; Schwär; Laubscher and Olivier (1984) 10 - 11; Strauss (1991) 3, 6, 31, 89; Claassen and Verschoor (1992) 69, 75. For South African case law authority see: *Stoffberg v Elliott* (1923) 150; *Esterhuizen v Administrator v Elliot* (1957) 716; *S v Mahaci* 1993 (2) SACR 36 at 47 - 48.

<sup>118</sup> For the Common Law legal writings see Van Oosten *Encyclopaedia* (1996) 64; See also Claassen and Verschoor (1992) 59. The authors state that: "*A patient can expressly consent to a medical intervention by way of speech or writing.*" See further Strauss and Strydom (1967) 187; McQuoid-Mason and Strauss *LAWSA* Volume 17 (1993) 147; See further Gordon, Turner and Price (1953) 156; Strauss and Strydom (1967) 187; See also Strauss (1991) 9; Dada McQuoid-Mason (2001) 5. For the position reflected in the South African Case Law see *Stoffberg v Elliott* 1923 (CPD) 148 in which Watermeyer J with reference to the requirement of consent stated: "*Unless his consent to an operation is expressly obtained, any operation performed upon him without his consent (sic) is an unlawful interference with his right of security and control of his own body, and is a wrong entitling him to damages if he suffers any.*"

Watermeyer's statement in *Stoffberg v Elliott supra* has quite correctly come under criticism by our legal writers. See Gordon Turner and Price (1953) 155 - 156. The authors in their criticism stated: "*It must be confessed that this passage is not entirely convincing; it is obvious, for example, that the law was somewhat overstated when the learned Judge suggested that no valid consent could arise by implication. But there is a clear warning in it to the careful practitioner: If he is in the least doubt as to the validity of an implied consent, he should obtain an express consent, preferably written and witnessed, in accordance with the form suggested on page 162.*" *Contra* Van Oosten *Encyclopaedia* (1996) who states that "*Watermeyer statement in Stoffberg v Elliott that consent to an operation must be express overlooks the fact that implied consent to medical interventions suffices.*" See also Strauss and Strydom (1967) 187.

<sup>120</sup> or may even be implied from the patient's conduct. <sup>121</sup>

As a general rule however saves where regulated by legislation, there is no legal requirement for consent to be in written form. For that reason oral and implied consent are equally valid.

#### 4.6.3.1.1 Expressed Consent

Expressed consent, as was previously stated, may either be granted orally or in writing, there being no legal requirement, unless provided for by legislation.

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<sup>119</sup> See Strauss and Strydom (1967) 187 - 188. The authors recognize the validity of a patient's oral consent in that where the patient verbally consents to the medical intervention but has undisclosed mental reservations about it, but nevertheless submits himself, apparent consent must be taken as real consent. Also where the patient for fear of pain or injury verbally refuses a medical intervention but nevertheless subjects him or herself, tacit consent must be taken to have been granted. See also Van Oosten *Encyclopaedia* (1996) 64; See further Claassen and Verschoor (1992) 59. The authors are of the view that "*consent is usually given by way of requesting a practitioner to administer a particular treatment or to perform an operation.*" See also Strauss (1991) 4; McQuoid-Mason and Strauss (1983) *LAWSA* Volume 17 Par 147; Dada and McQuoid-Mason (2001) 8. The writers take the view that "*there is no difference between a written and oral consent in law except that the latter is easier to prove if there is a subsequent dispute.*" See also Van Oosten *The Doctrine of Informed Consent in Medical Law* (an unpublished thesis) (1989) 354 in which the writer opine that "*oral disclosure and consent will usually suffice, although written disclosure and consent will, of course, facilitate their proof.*"

<sup>120</sup> See Van Oosten (unpublished thesis) 1989 354. The author states that "*it is generally acknowledged that a discussion and dialogue between doctor and patient are of paramount importance. Written disclosure and consent may, at best, form a basis for and supplement or support oral disclosure and consent.*" See also Van Oosten *Encyclopaedia* (1996) 64; See further Strauss and Strydom (1967) 187 in which the authors take the view that the importance of written consent is to be found in the fact that it is to prove if there is a subsequent dispute as well as in instances where the medical practitioner engages in involved or complicated treatment or surgery. See further Dada and McQuoid-Mason (2001) 8; Strauss (1984) 9; McQuoid-Mason and Strauss *LAWSA* Volume 17 (1983) Par 147; Gordon Turner and Price (1953) 155-156, 161-162. Certain legislative provisions set it as a prerequisite that consent be reduced to writing. See Section 60 A (3) of the *Mental Health Act*, No 18 of 1973. It provides *inter alia* that: "*If a patient is on account of his mental illness, not capable of consenting to medical treatment to, or an operation on, himself, then depending on which category of person is required to consent, such consent is required to be in writing.*" See also Section 4(c) of the *Sterilization Act*, No 44 of 1998. It provides that: "*Consent given for sterilization to be performed on a patient, must be in writing, with the consent form duly signed.*" See further Section 18 of the *Human Tissue Act*, No 56 of 1983. It also provides that: "*The removal of tissue, blood and gametes for transplantation purposes, may only be executed if consent has been obtained, from the donor or his or her parents in writing.*"

<sup>121</sup> For the legal writer's opinion on implied consent see Claassen and Verschoor (1992) 59 - 60. The authors recognize this form of consent when they state: "*Consent may also be constituted by a tacit submission to treatment. Mere acquiescence is no consent, but where a person capable of forming an intention, submits himself to medical treatment the nature of which he is acquainted with, without any resistance or protest, the conclusion will normally be made that he impliedly consented thereto.*" See also McQuoid-Mason and Strauss *LAWSA* Volume 17 (1983) Par 147; Gordon Turner Price (1953) 153; Van Oosten *Encyclopaedia* (1996) 64; See further Strauss and Strydom (1967) 187. The authors lay down the test for determining whether the patient consented or not namely it being a question of fact in looking at the conduct of the patient against all the surrounding circumstances. Dada and McQuoid-Mason (2001) 8.

In most instances in practice however, the expressed consent by a patient, is obtained orally. Though written consent, as was stated earlier, is not a requirement unless so regulated by statute, nonetheless, in practice as a general rule, when a patient enters a hospital or undergoes surgery, written consent is required.

It has therefore become a rule of practice in South African Hospitals, albeit provincial hospitals or privately owned hospitals that patients are required to sign pro forma admission forms which usually incorporate an express consent clause which the patient is required to sign.

One of the greatest advantages in getting a patient to sign such written consent, especially where the nature of the type of treatment and the nature of the surgery to be performed are included in the consent form, is founded in the fact that it is usually very precise and provides better evidence that the patient's permission had been obtained.<sup>122</sup>

Some private hospitals have even gone so far in exploiting expressed consent practices by including exemption clauses, alternatively known as exculpatory clauses, in the pro forma admission forms in an attempt to exempt themselves from liability, to the effect that the hospital will not be liable for any injury, loss or damage of whatever nature suffered by the patient arising out of any treatment or attention received or defects in the premises or instruments of the hospital, whether it is due to the negligence of the hospital or its staff or servants or not.<sup>123</sup>

The above will form the subject of the investigation into whether such waiver agreements between doctor/hospital and patients, excluding liability for medical malpractice, are valid and if not, whether they should not be regarded as invalid, such agreements being *contra bonos mores*.

#### 4.6.3.1.2 Implied Consent

Implied consent to medical treatment, as was seen earlier, may be inferred from the words

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<sup>122</sup> See Strauss (1991) 9. The author states that written and signed consent is "of the utmost importance in safeguarding the doctor against unwarranted legal proceedings." See also Strauss and Strydom (1967) 187. The authors attach value to written consent in that it is easier to prove a fact if there is a subsequent dispute. See further Dada and McQuoid-Mason (2001) 8; Claassen and Strydom (1967) 59; Strauss (1991) 9; McQuoid-Mason and Strauss (1983) *LAWSA* Volume 17 147; Gordon Turner and Price (1953) 155 - 156; 161 - 162.

<sup>123</sup> See Cronje-Retief *The Legal Liability of Hospitals* (2000) 440; See also Claassen and Verschoor (1992) 102 - 103; See further Burchell and Schaffer "Liability of Hospitals for Negligence" *Businessman's Law* (1977) 109 - 111; See further Claassen and Verschoor (1992) 102 - 103; Strauss (1991) 348; Strauss and Strydom (1967) 324.

or conduct of the patient. Although, generally, it is not hard to imply consent in obvious cases, for example, a patient goes and lies on a bed in the doctor's surgery or consulting rooms or a patient presents his or her arms for an injection or a patient finds himself or herself in the consulting rooms of a dentist or a doctor and opens his or her mouth for an examination, nevertheless, a mere submission by the patient, does not amount to consent. What is required is the submission to treatment by the patient, as well as a manifestation of the will to consent.<sup>124</sup>

#### 4.6.3.1.3 Informed Consent

The doctor-patient contractual relationship as was previously stated is a consensual one in which *consensus ad idem* in relation to medical treatment and/or surgery is of paramount importance. Consent, as was also previously stated, is a manifestation of the parties reaching consensus. Consensus on the other hand, it is submitted, can never be achieved, unless there is a meeting of the minds between the doctor and his or her patient.

One way of achieving this, is the exchanging of information between the doctor and patient. It is this parting of appropriate information and the acquisition of knowledge and Appreciation, of material risks of complications, which will put the patient in a position to make an informed decision. The exchange of information in which the patient acquires knowledge and appreciation in order to put him in a position to make in informed decision is also known as informed consent.

##### 4.6.3.1.3.1 The Nature and Scope of Informed Consent

The concept of "informed consent" has been defined as indicating that the person, who consents, knows and appreciates what it is that he consents to.<sup>125</sup> Most of our legal

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<sup>124</sup> For the views expressed by the Common Law legal writers see Dada and McQuoid-Mason (2001) 9. The authors define the manifestation of the will as "*patients capable of submitting themselves to medical treatment in the full knowledge of the nature thereof, and offering no resistance or make no objection to such treatment.*" From the definition it is clear that only those patients capable of consenting may provide valid consent. For that reason the authors Dada and McQuoid-Mason caution: "*Tacit or presumed consent will not be inferred in the case of young children or mentally ill or defective persons, as they do not have the legal capacity to give an informed consent.*" See also McQuoid-Mason *LAWSA* Volume 17 147; See further Claassen and Verschoor (1992) 59 - 60; Gordon Turner and Price (1955) 153; Van Oosten *Encyclopaedia* (1996) 64. For the test in determining whether the patient consented or not, see Strauss and Strydom (1967) 187. The authors advocate that this can be determined by looking at the conduct of the patient against all the surrounding circumstances of a case.

<sup>125</sup> See Strauss (1991) 6 14 - 15; See also Smit "Enkele opmerkings aangaande eksperimentering op menslike wesens deur medici" 1975 *THRHR* 254; See further Burchell "Informed Consent Variations on a Familiar Theme" 1986 *MED and LAW* 293; See further Van Oosten - The Doctrine of Informed Consent in Medical Law (unpublished thesis) (1989) 20 58.



writers,<sup>126</sup> as well as the South African case law,<sup>127</sup> put a premium on the presence

<sup>126</sup> For the recognition and requirements set for informed consent see Van Oosten *Encyclopaedia* (1996) 67 - 68 The author expresses the view that as with "ordinary, lawful consent, in which the consenting party knows what he or she consents to, in medical matters, knowledge and appreciation are also prerequisites for obtaining lawful consent." See also Claassen and Verschoor (1992) 62. The authors similarly take the view that "a person must have knowledge of all the true and essential facts relating to the treatment he is consenting to." In a medical contract the authors opine: "Consent will therefore only be valid where it is based on essential knowledge regarding the nature and effect of the proposed treatment, consent must accordingly be "informed"."

See also Strauss and Strydom (1967) 209; McQuoid-Mason and Strauss *LAWSA* Volume 17 (1983) 149. *Contra* Gordon Turner and Price (1953) 157: "In such a case it is clear that the patient should have been left in no doubt as to the exact nature of the operation proposed, but the question is not always so simple. The practitioner has to compromise between, on the one hand, failing to explain enough to the patient to get his clear and understanding consent, in which case he may lay himself open to a complaint of assault, and, on the other hand, explaining so much that the patient takes fright and refuses to undergo treatment which is really necessary and desirable, in which case the practitioner may lay himself open to a complaint of malpractice as well as the unsatisfactory realisation that he has morally and ethically, if not legally, failed his patient." See also Strauss (1991) 6 - 7. The author supports the view that knowledge and appreciation "are two of the basic elements of consent." The author also expresses the view that "as a general rule there is no question of legal consent unless the party concerned is fully au fait with what he is consenting to." But cautions the author that in the medical field this requirement is not without problems in that: "There may be some doubts in the doctor's mind on the correctness of the diagnosis; there may be alternative methods of treatment for a particular case; many medical procedures involve a certain amount of risk; the effects of the treatment undertaken may not be altogether predictable; a successful outcome cannot always be guaranteed; there is the possibility of an idiosyncratic reaction in the patient to be reckoned with. The question is, considering these difficulties, to what extent the patient should be apprised of the diagnosis, the nature of the treatment proposed, and the inherent risks of such treatment." In so far as diagnosis is concerned Strauss expresses the view: "There is no duty upon the doctor to inform the patient fully of the diagnosis. The diagnosis concerns the question why? It may be based on a complexity of symptoms and it involves scientific assessment of the case on the basis of the doctor's knowledge, skill and experience. It may be impractical to attempt giving the patient a general indication in layman's language of the diagnosis. The full diagnosis must be given only where the patient stipulates this as a condition to giving his consent to an operation or treatment." As to the treatment which must be given and expected results of the treatment as well as the medical profiant proposed, see Strauss (1991) 7 who opines: "The nature of the medical procedures proposed should be described in simple terms to the patient where a final diagnosis is impossible in the absence of an exploratory operation, or where there is the possibility of extension of the operation agreed upon the patient should be so informed in such detail that he may apply his mind intelligently." But cautions the author: *The patient should, in unequivocal terms, be informed of those results that are inevitable, egg where a colostomy will be undertaken, the patient must be told that he will be fitted with an artificial opening of the colon on the surface of the body, where a hysterectomy is undertaken, the woman should be told in simple terms that she will be unable to bear children.*" As to the danger of risks the author advises: "Where there are 'serious risks' involved in shock therapy for neurosis, the patient must be apprised of these." *Contra* Van Oosten *Encyclopaedia* (1996) 69 who with regard to the nature and scope of the information the medical practitioner is obliged to disclose. The author opines that: "..... the doctor is obliged to give the patient a general idea in broad terms and in a layperson's language of the nature, scope, consequences, risks, dangers, complications, benefits, disadvantages and prognosis of, as well as the alternative to, the proposed intervention. More particularly, all serious and typical risks and dangers should be disclosed, but not unusual or remote risks unless they are serious or typical, respectively, or the patient makes enquiries about them." But the author recognizes that various factors may influence the medical practitioner's disclosure. The circumstances referred to are: "..... the matter to be disclosed, the nature of the medical intervention, the patient's desire to be informed, the patient's temperament and health and the patient's intelligence and understanding. However, the doctor should avoid causing the patient anxiety and distress by an unnecessary disclosure of an adverse diagnosis or the adverse consequences of the proposed intervention."

<sup>127</sup> In so far as the recognition of the patient's consent as an essential for lawful medical intervention is concluded, the South African courts in a number of cases have recognised this principle. See in this regard: *Zurnamer v Thielke* 1914 CPD 176 178; *McCallum v Hallen* 1916 EDL 74 82; *Stoffberg v Elliott* 1923 CPD 148 149 - 150;



*Lymberry v Jefferies* 1925 AD 236 240; *Prowse v Kaplan* 1933 EDL 257 260 - 261; *Allott v Paterson and Jackson* 1936 SR 221 224; *Recsei's Estate v Meine* 1943 EDL 277 283 - 290; *Layton and Layton v Wilcox and Higginson* 1944 SR 48 50 - 51; *Ex parte Dixie* 1950 (4) SA 748 (W) 751; *Rompel v Botha* 1953(T) (unreported), discussed in *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710(T) 719; *Lampert v Hefer* 1955(2) SA 507(A) 508; *Richter v Estate Hammann* 1976 (3) SA 226(C) 232. The doctor's duty to inform the patient also has a very long history. The first case in which this duty was recognised was that of *Lymberry v Jefferies* 1925 AD 236. See also *Prowse v Kaplan* 1933 EDL 257; *Dube v Administrator Transvaal* 1963 (4) SA 260 (W); *Rompel v Botha* 1953 (T) (unreported, discussed in *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) 719; *Richter v Estate Hammann* 1976 (3) SA 226 (C); *Edouard v Administrator Natal* 1989 (2) SA 368 (D) 371, 385; *Mtewa v Administrator Natal* 1989 (3) SA 600 (D) 604. As to what information the medical practitioner is to share with the patient see the remark made by Wessel J in *Lymberry v Jefferies* 1925 AD 236 at 240: "All the surgeon is called upon to do is to give some general idea of the consequences. There is no necessity to point out meticulously all the complications that may arise." In a later judgement of *Rompel v Botha* 1953 (T) (unreported), discussed in *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) 719: "I have no doubt that a patient should be informed of the serious risks he does run. If such dangers are not pointed out to him then, in my opinion the consent to the treatment is not in reality consent. It is consent without knowledge of the possible injuries. On the evidence defendant did not notify plaintiff of the possible dangers, and even if plaintiff did consent to shock treatment he consented without knowledge of injuries which might be caused to him." The above principle was endorsed in *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) 721: "I do not pretend to lay down any such general rule; but it seems to me, and this is as far as I need go for purposes of a decision in the present case, that a therapist, not called upon to act in an emergency involving a matter of life or death, who decides to administer a dosage of such an order and to employ a particular technique for that purpose, which he knows beforehand will cause disfigurement, cosmetic changes and result in severe irradiation of the tissues to an extent that the possibility of necrosis and a risk of amputation of the limbs cannot be excluded, must explain the situation and resultant dangers to the patient no matter how laudable his motives might be and should he act without having done so and without having secured the patient's consent, he does so at his own peril." Although the term "informed consent" was first used in *Verhoef v Meyer* 1975 (T); 1976 (A) (unreported), discussed in Strauss (1991) 32 - 33, it was only much later in the case of *Castell v De Greeff* 1994 (4) SA 408 CPD 408 when the doctrine was formally recognised and received into South African Law. Referring to Van Oosten *The doctrine of informed consent in medical law* (unpublished doctoral thesis, University of South Africa (1989) at 414 in which the learned author opines: "When it comes to a straight choice between patient autonomy and medical paternalism, there can be little doubt that the former is decidedly more in conformity with contemporary notions of and emphasis on human rights and individual freedoms and a modern professionalised and consumer-orientated society than the latter, which stems largely from a bygone era predominantly marked by presently outmoded patriarchal attitudes. The fundamental principle of self-determination puts the decision to undergo or refuse a medical intervention squarely where it belongs, namely with the patient. It is, after all, the patient's life or health that is at stake and important though his life and health as such may be, only the patient is in a position to determine where they rank in his order of priorities, in which the medical factor is but one of a number of considerations that influence his decision whether or not to submit to the proposed intervention. But even where medical considerations are the only ones that come into play, the cardinal principle of self-determination still demands that the ultimate and informed decision to undergo or refuse the proposed intervention should be that of the patient and not that of the doctor." The court duly endorsed the principle. Referring further to two leading decisions of the Australian Courts on the standard of disclosure required of a doctor in treating a patient namely *F v R* (1983) 33 SASR 189 and *Rogers v Whitaker* (1993) 67 ALJR 47 Ackermann J in *Castell v De Greeff* op cit at 426 quotes with approval the conclusion come to in *Rogers v Whitaker* namely: *The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege.*" And concludes at 427: "In my view we ought, in South Africa, to adopt the above formulation laid down in *Rogers v Whitaker*, suitably adapted to the needs of South African jurisprudence. It is in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving. This formulation also sets its face against paternalism, from many other species whereof South African is now turning away. It is in accord with developments in common law countries like Canada, the United States of America and Australia, as well as judicial views on the continent of Europe. The majority view in *Sidaway* must be regarded as

of knowledge and appreciation with the patient before real consent can be achieved.

Informed consent, it is submitted, serves a twofold function. On the one hand, it is essential to establish a proper doctor-patient relationship which ultimately enhances a healthy doctor-patient relationship;<sup>128</sup> on the other hand, it is also essential for lawful medical interventions.<sup>129</sup>

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*out of harmony with medical malpractice jurisprudence in other common law countries. I therefore conclude that, in our law, for a patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment; a risk being material if in the circumstances of the particular case:*

- (a) *a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or*
- (b) *the medical practitioner 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 therapeutic privilege, whatever the ambit of the so-called 'privilege' today still may be."*

<sup>128</sup> It is particularly Van Olsten who recognizes that the doctrine of informed consent has made a major contribution in the change in the doctor-patient paradigm in that *"patient autonomy as a fundamental right has been endorsed and medical paternalism rejected."* The effect thereof has been put that *"the ultimate decision to undergo (informed consent) or refuse (informed refusal) a medical intervention lies with the patient and not with the doctor."* See Van Oosten 1996 68; See also Van Oosten *The Doctrine of Informed Consent in Medical Law* (1989) 12 - 13 414. This shift in the doctor-patient paradigm in which the fundamental right of individual autonomy and self determination as opposed to paternalism is preferred by our courts and may be deduced from the judgement of Ackermann J in *Castell v De Greeff* 1994 (4) SA 408 at 426 in which the judge endorses the principle laid down in *Rogers v Whitaker*: *"It is in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving. This formulation also sets its face against paternalism, from many other species whereof South Africa is now turning away. It is in accord with developments in common law countries like Canada, the United States of America and Australia, as well as judicial views on the continent of Europe. The majority view in Sidaway must be regarded as out of harmony with medical malpractice jurisprudence in other common law countries."*

<sup>129</sup> See generally the legal writings of the common law writers who are *ad idem* that informed consent is in the absence of other grounds of justification a requisite. For lawful medical interventions regardless of whether they take the form of treatment or experimental in that consent serves as a defence to criminal and/or civil liability. See Van Oosten *The Doctrine of Informed Consent in Medical Law* (1989) 11 13 20 31 - 33 54 56-57 445 - 446. See also Van Oosten *Encyclopaedia* (1996) 67 - 68; Claassen and Verschoor (1992) 62 - 63; Dada and McQuoid-Mason (2001) 13 - 14; Strauss (1991) 3 - 46 27 70 - 71; See further McQuoid-Mason and Strauss *LAWSA Volume 17* (1983) 149. In regard to grounds of justification for example necessity, negotiorum gestio, statutory authority in the general context see Loubser in *LAWSA Volume 6* (1981) (ed Joubert) par 63; Burchell, Milton and Burchell *South African Criminal Law and Procedure 1* (1983) 372; Boberg *The Law of Delict 1* (1984) 751; Strauss (1991) 3 27 70 ff; De Wet *Strafreg* (1985) 102; Van der Merwe and Olivier *Die Onregmatige Daad in die Suid-Afrikaanse Reg* (1985) 107 - 108; Snyman *Strafreg* (1986) 133 - 134; Visser and Vorster *General Principles of Criminal Law through the Cases* (1987) 197. For grounds of justification in a medical context see Van Oosten *Encyclopaedia* (1996) 76 -78. The authors highlights that in the following situations informed consent does not have to be obtained prior to medical interventions namely:

- (i) Deviations or extensions: - In this regard during for example surgery, the doctor discovers that an undiagnosed condition exists, which renders *"a deviation or extension of the agreed operation necessary or reasonable where otherwise, the patient's medical interests may be detrimentally affected."* *Contra* however Strauss and Strydom (1967) 223 - 224: The authors identify the following situations as justifiable deviating or extensions *inter alia*: *"Where the patient consents to the intervention in question, but not to it being negligently performed, and where the patient consents to the intervention in question,*



*but is not fully informed of all the consequences thereof.*" See also the situations described in the following case law: *Esterhuizen v Administrator Transvaal* (1957) (T) 716 in which consent to the initial superficial radiotherapy was held not to cover the subsequent radical radiotherapy, the patient's allegation in *Verhoef v Meyer* (1976) AD 33 (unreported) that not only had the right eye been operated upon as agreed, but also her left eye for which no consent was given, the patient's allegation in *Fowlie v Wilson* 1993 (N) (Unreported) that consent had been given to a laparoscopy but not to subsequent cancer surgery.

- (ii) Emergency interventions: - This may arise independent of emergency interventions, justified by statutory authority *inter alia* Rules 27, 28 and 29 of the *South African Health Services Council Rules of Conduct*. For South African case law see: Cf. *Stoffberg v Elliott* (1923) CPD 148 at 150; *Ex parte Dixie* 1950 (4) SA 748 (W) at 751; *Rompel v Botha* 1953 (T) (unreported); *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 T at 716 ff; *Burger v Administrator Kaap* 1990 (1) SA 483 (C) 489. It may arise in unauthorized administration situations better known as *negotiorum gestio* or necessity situations. In these situations the patient as a result of unconsciousness, delirium, shock or loss arising from indulgence or accident is unable to give consent to a medical intervention, which is urgently necessary to save his or her life or to preserve his or her health the action taken must be in the patient's best interests. In necessity situations, even if the patient is capable of consenting, in some instances action taken in these situations will connote lawful medical interventions. In this regard Van Oosten *Encyclopaedia* (1996) 74 states: "*Necessity as a defence will therefore be relevant where the patient was capable of consenting or where the intervention was against his or her will or where the intervention was performed in society's best interest. Thus the inoculation of conscious, sane, sober and healthy persons against their express wish in order to prevent a dangerous and infectious disease from spreading may be justified in necessity.*" See also Strauss (1991) 31 91 - 92 who takes the view that: "*Medical treatment of a patient whose life or health is in serious danger against the patient's express wishes will be justifiable in necessity only if it is administered solely (a stringent qualification which may conceivably give rise to difficulties) for the protection of society's interest, cf. GN R2438 of 30 October 1987 Regulation 13 under Section 33(1) (j) of the Health Act.*"
- (iii) Statutory authority:- Some acts in the form of medical interventions may, even in the absence of informed consent, be justified by statute, for example: "..... *the taking of a blood sample which may be relevant to criminal proceedings, a compulsory medical examination, hospitalization and treatment or immunization of persons suspected on reasonable grounds of being carriers of communicable diseases; or psychiatric treatment administered to a mental patient institutionalized in terms of a compulsory detention order.*" For the relevant statutory provisions see: Section 37(2) of the *Criminal Procedure Act*; cf. also Section 225(2). In terms of GV R2438 of 30 October 1987 Regulations 14 and 17 under Section 33(1) (r) of the *Health Act*. In terms of GN R2438 of 30 October 1987 Regulation 13 under Section 33(1) (j) of the *Health Act*. Sections 1 and 9(3) of the *Mental Health Act*.
- (iv) Court authorization: - Authorization by the court may justify a medical intervention. This may be justified regardless of the medical intervention be against the patient's will or not.

The ratio for informed consent being essential for lawful medical interventions has been discussed differently by our common law writers. See Gordon, Turner and Price (1953) 153. The authors emphasize their standpoint namely: "*Consent vitiates otherwise conduct which would otherwise have been regarded as civil and/or criminal assault.*" See also Strauss (1991) 3; See also Van Oosten *The Doctrine of Informed Consent in Medical Law* (1989) 56; Millner "The Doctor's Dilemma" 1957 *SALJ* 389; Burchell "Informed Consent Variations on a Familiar Theme." 1986 *Med and Law* 298; Smit "Enkele Opmerkings aangaande eksperimentering op Menslike wesens deur Medici" 1979 *THRHR* 267 -258 259 262; See further McQuoid-Mason and Strauss *LAWSA* 1983 Volume 17 146. *Contra* Claassen and Verschoor (1992) 57 - The authors on the other hand places a great premium on the "personal integrity and right of self-determination of the patient". See also Van Oosten *Encyclopaedia* (1996) who equally places great emphasis on the patient's autonomy. In this regard the writer describes the purpose and function of informed consent as: "*(a) To ensure the patient's right to self-determination and freedom of choice; and (b) to encourage rational decision-making by enabling the patient to weigh and balance the benefits and disadvantages of the proposed intervention in order to come to an enlightened choice either to undergo or refuse it.*" The writer cautions: "*In the absence of other grounds of justification, medical interventions without the patient's informed consent on the basis of the patient's-best-interest and the doctor-knows-best criteria constitute a violation of the patient's autonomy.*" See in this regard the South African case law: *Stoffberg v Elliott* (1923) 146 at 149 - 150; *Ex parte Dixie* 1950(4) SA 748 (W) 51; *Esterhuizen v Administrator Transvaal* 1957 (3) SA



The relationship between health care providers and their personnel and the health care users imposes certain rights and duties on users as well as the health care providers and their personnel. The National Health Act<sup>130</sup>, it is submitted, oversees that such a relationship is fostered and promoted.<sup>131</sup> Some of the primary duties and obligations of a health care provider and its staff involves the sharing of information with the user of health services regarding his/her health status, diagnostic procedures and treatment options and the risks involved.<sup>132</sup> The underlying reason for sharing the information with the user is for the user to make an informed decision. The user's informed consent is necessary before any treatment can commence or surgery is carried out, save for instances where, due to circumstances, consent is not necessary.<sup>133</sup> The participation of the health service user in

710(T) 918, 720; *Castell v De Greef* (1994) (4) SA 408 (CPD) at 420 - 421. It is particularly since the *Castell v De Greef* (1994) (4) SA 408 CPD cases that patient autonomy as model governing the doctor-patient relationship has received recognition and acceptance, thus displacing medical paternalism as a preferred model. Since the said judgement the emphasis has shifted from the doctor taking action or making important decisions on behalf of patients to the doctor telling the whole truth to the patient and the doctor having greater accountability for medical decisions and with the patient having a greater right to self-determination. It is the scope of patient autonomy and his or her right to self-determination which will form the focal point of this thesis in determining whether an exemption clause excluding liability for intentional medical malpractice or for gross medical negligence alternatively negligence will be upheld by our courts or not.

<sup>130</sup> Act 61 of 2003.

<sup>131</sup> The National Health Act 61 of 2003 it is submitted imposes certain duties and obligations against the backdrop of the Constitution. One just has to have regard to the preamble of the Act which provides for the aim and objectives of the provisions of the Act, namely; *"to provide a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services; and to provide for matters connected therewith."* Pearmain (2004) 523 with reference to the work of Christie *The Law of Contract* 4<sup>th</sup> ed 322 advances the argument that the disclosure of information to the patient fits the paradigm proposed namely, the duties within the fiduciary relationship in which the interests of the patient is primal.

<sup>132</sup> The duties of the healthcare provider and its personnel are contained in Chapter 2 of the National Health Act No 61 of 2003. Section 6 provides:  
*" User to have full knowledge (1) Every health care provider must inform a user of –*  
 (a) *the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;*  
 (b) *the range of diagnostic procedures and treatment options generally available to the user;*  
 (c) *the benefits, risks, costs and consequences generally associated with each option; and*  
 (d) *the user's right to refuse health services and explain the implications, risks, obligations of such refusal.*  
 (2) *the health care provider concerned must where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a manner which takes into account the user's level of literacy.*

<sup>133</sup> *"Consent of user (1) Subject to section 8 a health service may not be provided to a user without the user's informed consent, unless-*  
 (a) *the user is unable to give informed consent and such consent is given by a person-*  
     (i) *mandated by the user in writing to grant consent on his or her behalf; or*  
     (ii) *authorized to give such consent in terms of any law or court order;*  
 (b) *the user is unable to give informed consent and no person is mandated or authorized to give such consent, and the consent is given by the spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the user, in the specific order as listed;*  
 (c) *the provision of a health service without informed consent is authorized in terms of any law or a court order;*  
 (d) *failure to treat the user, or group of people which includes the user, will result in a serious risk to public health; or*

the decision making process is encouraged by the Health Care Act.<sup>134</sup> The Act also lays down certain requirements where consent cannot be obtained.<sup>135</sup>

#### 4.6.3.1.4 Requirements for Valid Consent

As was previously stated, consent will only be valid if it is based on the imparting of appropriate information by the doctor and the acquiring of substantial knowledge by the patient, of the nature and effect of the act consented to.

The question therefore needs to be begged, what information needs to be parted with and further, what is the extent of the information the patient ought to acquire before he validly consents? An assessment of the relevant literature<sup>136</sup> pertaining to real consent reveals that real consent can never be achieved unless the following requirements are first met. It is especially, the following writings which influenced modern thinking. The requirements include:

- Consent must be recognised by law, that is, it must not be *contra bonos mores*. In

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- (e) *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.*
  - (2) *A health care provider must take all reasonable steps to obtain the user's informed consent.*
  - (3) *For the purpose of this section "informed consent" means 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."*

<sup>134</sup> Sec "8. *Participation in decisions*

- (1) *A user has the right to participate in any decision affecting his or her personal health and treatment.*
- (2) (a) *If the informed consent required by section 7 is given by a person other than the user, such person must, if possible, consult the user before giving the required consent.*  
(b) *A user who is capable of understanding must be informed as contemplated in section 6 even if he or she lacks the legal capacity to give the informed consent required by section 7.*
- (3) *If a user is unable to participate in a decision affecting his or her personal health and treatment, he or she must be informed as contemplated in section 6 after the provision of the health service in question unless the disclosure of such information would be contrary to the user's best interest."*

<sup>135</sup> Sec "9. *Health service without consent*

- (1) *Subject to any applicable law, where a user is admitted to a health establishment without his or her consent, the health establishment must notify the head of the provincial department in the province / in which that health establishment is situated within 48 hours after the user was admitted of the user's admission and must submit such other information as may be prescribed.*
- (2) *If the 48 hour period contemplated in subsection (1) expires on a Saturday, Sunday or public holiday, the health establishment must notify the head of the provincial department of the user's admission and must submit the other information contemplated in subsection (1) at any time before noon of the next day that is not a Saturday, Sunday or public holiday.*
- (3) *Subsection (1) does not apply if the user consents to the provision of any health service in that health establishment with 24 hours of admission".*

<sup>136</sup> It is particularly the writings of Van Oosten "The Doctrine of Informed Consent in Medical Law" (Unpublished LLD Thesis, Unisa, 1989) 17-13 which set out the criteria in the light of other writings which ought to be complied with before real consent can be deemed to have been given. Each requirement enumerated by Van Oosten will be dealt with in the text.



this regard Claassen and Verschoor <sup>137</sup> state that consent will only be a valid defence where the treatment consented to be not in conflict with public interest. Consent, for example, reckless medical experiments, euthanasia or unlawful abortions, according to the writers, will not exempt a practitioner from liability because such acts are considered *contra bonos mores*. It is against this background that the central theme of this thesis is carried out in ascertaining whether consent forms included in hospital admission forms containing waivers of liability are recognised by law, alternatively, whether they should not be regarded as invalid as they are considered *contra bonos mores*.

- It must be given by a person capable in law of consenting, that is, by someone who is capable of forming an intention (*wilsbevoeg*) or of understanding what he consents to. The traits needed to comply with this requirement have been stated before, meaning, when he is intellectually of sufficient maturity to understand the implications of his acts and when he is not mentally ill or under the influence of drugs which have an impeding effect on his brain. <sup>138</sup>
  
- It is also a requirement that consent must be free and voluntary, that is not induced by fear, force or fraud. <sup>139</sup> The writers Claassen and Verschoor are particularly assertive in their views when they state that there can be no question of legally valid consent when it has been obtained by using physical force on a patient. Consent also is invalid when a patient has been persuaded by fraudulent misrepresentation to agree to some or other medical treatment.
  
- A further requirement is that the consenting party must have had knowledge and been aware of the nature and extent of the harm or risk. This is one of the *essentialia* of informed consent in that the doctor is obliged to give the patient sufficient information for the patient to acquire the knowledge regarding the intervention as well as the risks, dangers, complications of the proposed

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<sup>137</sup> (1992) 60; See also Van Oosten *Encyclopaedia* (1996) 64; McQuoid-Mason and Strauss *LAWSA* Volume 17 (1983) Par 147.

<sup>138</sup> Claassen and Verschoor (1992) 60; Van Oosten *Encyclopaedia* (1996) 65-67. For a comprehensive discussion on who is capable of consenting and who is not and the influence of recent South African legislation governing consent see Carstens and Pearmain (2007) 897ff.

<sup>139</sup> Claassen and Verschoor (1992) 99; see also Gordon, Turner and Price (1953) 156 who state: "*The practitioner must be reasonably sure that the patient is a genuinely and actively consenting party, and that he is not submitting through fear or ignorance of his rights.*"

intervention.<sup>140</sup>

- The consenting party must also have appreciated and understood the nature and extent of the harm or risk. In this regard, it has been said before, that real consent cannot be attained unless the consenting party fully appreciates and understands the information communicated to her or him in this regard. The effect thereof is that this means that the doctor, as an expert, is saddled with a legal duty to provide the patient with the necessary information to ensure knowledge and appreciation, and hence, real consent on the patient's part.<sup>141</sup>
- But 'necessary information' does not mean that a practitioner needs to point out meticulously all the conceivable consequences which may arise, but he should at least inform the patient about the more serious risks involved in the operation or treatment.<sup>142</sup>
- A further requirement is that the consenting party must have consented to the harm or assumed the risk. The rationale behind this thinking is that real consent can only exist if the person who consents has knowledge of the danger and further, he or she consenting must have full appreciation of its nature and extent, he voluntarily elects to encounter or he takes the risk upon himself.<sup>143</sup>
- The extent of the information to be given also include that it must be comprehensive, extend to the entire transaction, inclusive of its consequences.<sup>144</sup>

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<sup>140</sup> See Van Oosten *Encyclopaedia* (1996) 69; See also Claassen and Verschoor (1992) 62-66 and the more recent writings of Carstens and Pearmain (2007) 883ff who deals comprehensively with the legislative requirements in terms of Section 6 of the *National Health Act* 61 of 2003 on how much detail to be given. For a discussion of the legislative requirements see supra.

<sup>141</sup> Claassen and Verschoor (1992) 63.

<sup>142</sup> McQuoid-Mason and Strauss *LAWSA* (1983) Volume 17 Par 149.

<sup>143</sup> Van Oosten (1996) 69ff. See also Van der Merwe and Olivier 6ed (1989) 92 96-97; See also Neethling, Potgieter and Visser (1989) 88. *Contra* Van der Walt (1979) 53-54. Although the author recognizes the defence of *volenti non fit iniuria*, the defence is not unlimited in that "the individual autonomy is limited by considerations of individual and social responsibility. Public interest requires that the capacity curtail one's rights and should be kept within reasonable bounds." The author continues: "Consent to or assumption of a risk is therefore only valid if it is not considered to be *contra bonos mores*". In determining whether consent is *contra bonos mores* the author suggests: "The prevailing legal convictions of the community with regard to the lawfulness of the particular conduct in question must be applied. The factors which should be taken into consideration are the nature and extent of the interests involved the motives of the parties and the social purpose of the consent or assumption of risk. This one can accept that consent to be killed or to be seriously injured without the presence of a serious social purpose is *contra bonos mores*". See further the discussion of Strauss (1964) *SALJ* 139, 182-184.

<sup>144</sup> Strauss (1991) 8 states that in the doctor-patient relationship, it is crucial for a doctor to ensure "that there should

- The next requirement is that the consent must be clear and unequivocal. <sup>145</sup>
- The writers also point out that consent must precede the conduct in question. <sup>146</sup>
- The consent given must qualify as a legal act. (Regshandeling) For that reason there must be external conduct which reveals the intention of the parties, namely, that consent has been given. <sup>147</sup>
- A further requirement is that consent, as a rule, must be granted by the plaintiff or the complainant, himself/herself. <sup>148</sup>
- Finally, it is also a requirement that the conduct in question must fall within the limits of the consent given, that is, it must not exceed the bounds of the consent given. <sup>149</sup>

The South African courts have also on a number of occasions set certain requirements which must be met before it can be said that real consent has been obtained in a medical context. In this regard our courts have placed certain duties on medical practitioners to disclose sufficient information regarding the nature and extent of the harm or risk in order for the consenting party to appreciate and understand the harm or risk. In the case of *Lymbery v Jefferies* <sup>150</sup> Wessels JA held *inter alia*: "*It is the duty of a surgeon, before*

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*subsequently be no question about what exactly the patient has consented to.*" As medical treatment often entails a certain amount of risk the author cautions: "*Upon the assumption that the patient has been adequately apprised of the risks involved, the next step is to ensure that the patient has left no doubt that he is prepared to undergo the suggested treatment notwithstanding the risk involved.*"

<sup>145</sup> Strauss (1991) 8; See also Carstens and Pearmain (2007) for a discussion on the nature and scope of the information to be declared as prescribed by Section 6 of the *National Health Act* 61 of 2003.

<sup>146</sup> Strauss *Toestemming tot Benadeling as Verweer in die Strafreg en die Deliktereg* (Unpublished ELD Thesis 1961 (Unisa) 108ff 110ff; See also McKerron (1971) 67-68; Van der Walt (1979) 51-52 53; Neethling, Potgieter and Visser (2000) 87-88.

<sup>147</sup> In this regard it is Van der Walt (1979) 54 who holds the view that "*in order to constitute a legal act the will and intention of the consenting party must be manifested by external conduct. Consent or assumption of a risk as particular states of mind must therefore be disclosed by some form of conduct.*" See also Van der Merwe and Olivier (1989) 90 99. See further Strauss *Toestemming* (1961) 22-23 33 34.

<sup>148</sup> Van der Merwe and Olivier (1989) 91; Van Oosten (1984) 19; Neethling et al (1989) 86.

<sup>149</sup> Van der Merwe and Olivier (1989) 91; Van Oosten (1984) 19; Neethling et al (1989) 86.

<sup>150</sup> 1925 AD 236.

*operating, to inform the patient that the operation is dangerous and may end in death, or that it will be accompanied by great pain and to obtain the patient's consent to such operation.*" <sup>151</sup>

In *Prowse v Kaplan* <sup>152</sup> the court held a dentist liable for his failure to disclose to the patient that he had fractured the patient's jaw, in an attempt to remedy a dislocation, which he had caused the patient during a previous operation upon her.

In *Dube v Administrator Transvaal* <sup>153</sup> the court recognised the hospital's duty to warn the patient clearly and unambiguously to return immediately once any abnormal symptoms became manifest.

Support for the view that a medical practitioner is under an obligation to disclose to the patient the nature and consequences of the treatment to be given can be found in the cases of *Rompel v Botha*<sup>154</sup>, discussed in *Esterhuizen v Administrator Transvaal*<sup>155</sup>, in which the court held that there is at least a duty upon medical practitioners to inform their patients of the serious risks they run.

In *Esterhuizen v Administrator Transvaal*, Bekker J, while accepting a medical practitioner's duty to inform the patient of the dangers attendant upon an operation made the following remarks:

*"Generally speaking to establish the defence of volenti non fit injuria the plaintiff must be shown not only to have perceived the danger, for this alone would not be sufficient, but also that he fully appreciated it and consented to incur it."*

and

*"Indeed if it is to be said that a person consented to bodily harm or to run the risk of such harm, then it presupposes, so it seems to me, knowledge of that harm or risk; accordingly mere consent to undergo X-ray treatment, in the belief that it is harmless or being unaware of the risks it carries, cannot in my view amount to effective consent to undergo the risk or the consequent harm."* <sup>156</sup>

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<sup>151</sup> *Lymbery v Jefferies* 1925 AD 236.

<sup>152</sup> 1933 (EDL) 257.

<sup>153</sup> 1963 (4) SA 260 (W).

<sup>154</sup> Unreported case 1953 (T).

<sup>155</sup> 1957 (3) SA 710 (T) 719.

<sup>156</sup> *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) 719.

The doctor's obligation to disclose was also dealt with in *Richter v Estate Hammann*.<sup>157</sup> Watermeyer J made the following remarks:

*"A doctor whose advice is sought about an operation to which certain dangers is attached, and there are dangers attached to most operations, is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient's interests to have it, it may well be negligent if he fails to warn a patient, and, if that is so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem. In reaching a conclusion 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. The court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence."*<sup>158</sup>

In *Castell v De Greef*<sup>159</sup> Ackerman J endorsed the requirements needed for consent to operate as a defence, as formulated by Van Oosten (1989) at 13-25:

- (a) *the consenting party must have had knowledge and been aware of the nature and extent of the harm or risk;*
- (b) *the consenting party must have appreciated and understood the nature and extent of the harm or risk;*
- (c) *the consenting party must have consented to the harm or assumed risk;*
- (d) *the consent must be comprehensive, that is extending to the entire transaction, inclusive of its consequences."*<sup>160</sup>

In *Friedman v Glicksman*<sup>161</sup> the court was tasked to consider whether an agreement between a pregnant woman and a doctor that he would advise her whether there was a greater risk than normal that she might have a potentially abnormal or disabled child so that she might make an informed decision on whether or not to terminate the pregnancy was *contra bonos* or not. Goldblat J held that such an agreement is sensible, moral and in accordance with modern medical practice. In respect of the medical practitioner's duty to disclose information concerning risk, the court held that if a doctor fails to inform a

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<sup>157</sup> 1976 (3) SA 226 (C).

<sup>158</sup> *Richter v Estate Hamman* 1976 (3) SA 226 (C) 232.

<sup>159</sup> 1994 (4) SA 408.

<sup>160</sup> *Castell v De Greef* 1994 (4) SA 408 at 425.

<sup>161</sup> 1996 (C) SA 1134 at 1138.

pregnant patient that she is at greater risk than normal of having an abnormal or disabled child, or incorrectly informs her that she is not at greater risk when she reasonably requires such information in order to make an informed choice whether to terminate such pregnancy, he is delictually liable to her for the damages she has suffered by giving birth to an abnormal or disabled child. The fault element of the delict is to be found in the foreseen ability of harm which the doctor-patient relationship gives to the doctor.

Although doctors are encouraged to give as much detail as possible, this depends upon the circumstances of each case. It further depends upon the patient's temperament and health and the patient's intelligence and understanding. As to the patient's temperament and health, in the case of *SA Medical Dental Council v McLoughlin*<sup>162</sup> in which Watermeyer CJ observed that it "*may sometimes even be advisable for a medical man to keep secret from his patient the form of treatment which he is giving him.*"<sup>163</sup>

As to the amount of information i.e. the extent of information a medical practitioner is obliged to furnish the patient, it was held in *Lymbery v Jefferies*<sup>164</sup> when Wessels JA remarked:

*"All the surgeon is called upon to do is to give some general idea of the consequences. There is no necessity to point out meticulously all the complications that may arise."*<sup>165</sup>

In a more comprehensive tone Nesor J in *Rompel v Botha* 1953 (T) unreported, discussed in *Esterhuizen v Administrator, Transvaal*<sup>166</sup> set out the scope of information that ought to be disclosed:

*"There is no doubt that a surgeon who intends operating on a patient must obtain the consent of the patient. In such cases where it is frequently a matter of life and death I do not intend to express any opinion as to whether it is the surgeon's duty to point out to the patient all the possible injuries which might result from the operation, but in a case of this nature, which may have serious results to which I have referred, in order to effect a possible cure for a neurotic condition, I have no doubt that a patient should be informed of the serious risks he does run. If such dangers are not pointed out to him then, in my opinion, the consent to the treatment is not in reality consent, it is consent without knowledge of the possible injuries. On the evidence defendant did not notify plaintiff of the possible dangers, and even if plaintiff did consent to shock treatment he consented without knowledge of injuries*

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<sup>162</sup> 1948 (2) SA 355 (A).

<sup>163</sup> *SA Medical Dental Council v McLaughlin* 1948 (2) SA 355 (A) 366. See also *Richter v Estate Harman* 1976 (3) SA 226 (C) at 232.

<sup>164</sup> 1925 (AD) 236.

<sup>165</sup> 1925 (AD) 236.

<sup>166</sup> *Lymbery v Jefferies* 1925 (AD) 236 at 240.



*which might be caused to him. I find accordingly that plaintiff did not consent to the shock treatment."* <sup>167</sup>

Endorsing the remarks made by Nesor J in *Rompel v Botha* 1953 (T) (unreported) Bekker J in *Esterhuizen v Administrator, Transvaal* <sup>168</sup> stated that it would render the position of the medical profession intolerable if it were to be held that they owed a duty to patients of having to inform them, prior to any operation or treatment, of all the consequences, dangers and details of the risks inherent in the operation or treatment. He remarked:

*"I do not pretend to lay down such general rule, but it seems to me, and this is as far as I need go for purposes of a decision in the present case, that a therapist, not called upon to act in an emergency involving a matter of life and death, who decides to administer a dosage of such an order and to employ a particular technique for that purpose, which he knows beforehand will cause disfigurement, cosmetic changes and result in severe irradiation of the tissues to an extent that the possibility of necrosis and a risk of amputation of the limbs cannot be excluded, must explain the situation and resultant dangers to the patient. No matter how laudable his motives might be and should he act without having done so and without having secured the patient's consent, he does so at his own peril."* <sup>169</sup>

The following views were expressed by Ackerman J in *Castell v De Greef*: <sup>170</sup>

*"It is clearly for the patient to decide whether she wishes to undergo the operation, in the exercise of the patient's fundamental right to self-determination. A woman may be informed by her physician that the only way of avoiding death by cancer is to undergo a radical mastectomy. This advice may reflect universal medical opinion and may be, in addition, factually correct. Yet, to the knowledge of her physician, the patient is, and has consistently been, implacably opposed to the mutilation of her body and would choose death before the mastectomy. I cannot conceive how the best interests of the patient (as seen through the eyes of her physician or the entire medical profession, for that matter) could justify a mastectomy or any other life-saving procedure which entailed a high risk of the patient losing a breast. Even if the risk of breast-loss were significant, a life-saving operation which entailed such risk would be wrongful if the surgeon refrains from drawing the risk to his patient's attention, well knowing that she would refuse consent if informed of the risk. It is, in principle, wholly irrelevant that her attitude is, in the eyes of the entire medical profession, grossly unreasonable, because her rights of bodily integrity and autonomous moral agency entitle her to refuse medical treatment. It would, in my view, be equally irrelevant that the medical profession was of the unanimous view that, under these circumstances, it was the duty of the surgeon to refrain from bringing the risk to his patient's attention."* <sup>171</sup>

Since the decision in *Castell v De Greef* (1994), the doctor's obligation to disclose information to a patient surfaced again in the decision of *Broude v Mcintosh*<sup>172</sup>, in which the

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<sup>167</sup> 1957 (3) SA 710 (T).

<sup>168</sup> *Rompel v Botha* 1957 (3) SA 710 (T) discussed in *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T).

<sup>169</sup> 1957 (3) SA 710 (T) at 718.

<sup>170</sup> 1994 (4) SA 408.

<sup>171</sup> *Castell v De Greef* 1994 (4) SA 408 at 420-421.

<sup>172</sup> 1998 (3) SA 80 (SCA).

court did not overturn the principle of informed consent laid down in the *Castell v De Greef* case. But, the court held that it was a strange notion that the surgical intervention of a medical practitioner whose sole object has been to alleviate the pain or discomfort of the patient, and who had explained to the patient what was intended to be done and obtained the patient's consent to it being done, should juridically be described, and juristically characterised, as an assault simply because the practitioner had 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.

In the case of *Jacobson v Carpenter-Kling*<sup>173</sup> an ear-nose and throat specialist was sued by the patient for damages arising from the lack of informed consent. It was alleged that there was a failure to provide information on the material risks inherent in the operation designed to relieve the patient's chronic sinusitis. Complications set in which required further corrective surgery. The court consequently relied on the decision of *Castell v De Greef* (1994) and found that it was sufficient for a doctor to indicate the body parts on which the operation would be performed and to indicate "danger areas" which might be affected, together with an indication that the required care would be exercised.

More recently the Supreme Court of Appeal in *Louwrens v Oldwage*<sup>174</sup> dealt with *inter alia* the aspect of informed consent in the surgical procedure performed by the defendant. The plaintiff went into hospital for surgery in the form of a laminectomy i.e. an operation to the back. After the operation he began to exhibit symptoms of claudication i.e. blockage of the arteries with resultant cramping in the left leg. The plaintiff blamed the defendant. The court *a quo* found for the plaintiff, the claudication being caused by defendant's surgical intervention. One of the issues raised on appeal was whether the Plaintiff had given informed consent to the surgical procedure performed by the Defendant. Mthiyane JA, delivering the judgement on behalf of the court, found that the defendant explained in detail to the plaintiff the surgical procedure he planned to do and which he eventually did. As to whether the plaintiff was warned of the risks involved, in compliance with the requirements enunciated in *Castell v De Greef* 1994 (4) SA 408 (C) at 425 H-I, Mthiyane JA found that as there was only a 2% chance of the risk occurring to the plaintiff, it was so negligible that it was not unreasonable for the defendant not to mention it. The doctor's failure did not constitute negligence.<sup>175</sup>

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<sup>173</sup> 1998 TPD (Unreported).

<sup>174</sup> 2006 (2) SA 161 (SCA).

<sup>175</sup> In this regard the court relied upon the dictum of Richter and Another v Estate Hammann 1976 (3) SA 226 (c)

#### 4.7 Summary and Conclusions

The law of contract has an important role to play in the doctor-patient relationship as well as the hospital-patient relationship, especially, private hospitals. The intention to contract is central to the question of whether or not a contract in fact came into being. In the doctor-patient relationship the contractual relationship still holds sway. Central to this, as was stated earlier, is the fact that the contractual relationship is a consensual one. Historically, the relationship is founded on trust. The doctor/hospital, influenced by their common law duties, including normative ethics, and their statutory duties which influence professional conduct undertakes to *inter alia* exercise reasonable care and skill towards the patient. The formation of the contract between the doctor/hospital and patient can only validly come into being provided certain requirements have first been met. The requirements desire consensus *ad litem*. This also includes firstly, the parties to the agreement must have the contractual capacity to enter into the contract, and secondly, the agreement must be one for performance. From which obligations arise. Generally the doctor/hospital is only expected to perform that which he/she/it had undertaken to do and nothing more, unless such undertaking was guaranteed.

Thirdly, the agreement between the doctor/hospital and the patient must not be against public policy or against good morals. Contracts against public policy and against good morals are generally unenforceable. In this regard it is most unfortunate that the Supreme Court of Appeal in the controversial dictum of *Afrox Healthcare v Strydom* persisted in placing the providing of medical services in the same category of other commercial services. This, it is submitted, regrettably, influenced the court to find that an exclusionary clause incorporated in a hospital admission form exonerating a hospital for liability arising from the hospital and its staff's negligence where the contrary was indicated, was not

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2326-11 in which a neuro-surgeon was found not to have been negligent in failing to warn the patient where on the evidence there was only a remote possibility of complications arising. The court said that the doctor's actions have to be tested by the standard of the reasonable doctor faced with the particular problem. In this regard Watermeyer J said the following: "*A doctor whose advice is sought about an operation to which certain dangers are attached – and there are dangers attached to most operations – is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient's interest to have it. It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem. In reaching a conclusion 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. The Court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence.*" For a comprehensive discussion on the criticism of the decision by the Supreme Court of Appeal see Carstens and Pearnain (2007) 685ff.

against public policy. The point is argued elsewhere, but it needs to be emphasized here, that the court, in *Afrox*, ignored the deep running principles of the past, in that, as the doctor/hospital and patient relationship is founded on long standing ethics, the doctor/hospital's duty to exercise reasonable care towards the patient cannot validly be waived by the stroke of a pen, induced by an enterprise who stand in a powerful bargaining position compared to that of the patient. It will also be argued elsewhere that to allow this situation to prevail, is to ignore the profound changes the Constitution has brought to the South African legal system and international recognition of the need to protect consumers from unconscionable, unfair clauses in contract. It also ignores the social responsibilities of the doctor or hospital, in which, it is submitted, and the doctor and hospital stand in a position of trust.

Generally, unlike other commercial contracts, for example property transactions, no legal formalities are required to conclude a valid contract between the doctor/hospital and the patient. It is especially, where more serious operations are undertaken or the medical practitioner engages in unusual treatment of the patient, that it has become customary that the agreement is reduced to writing. Where, for example, a patient is admitted to hospital, the patient is required to sign an admission form which serves as an agreement between the medical practitioner/hospital and the patient.

The terms to the contract between the doctor/hospital and patient, whether in written form or orally, comprises different terms. Whether expressed or implied, when concluding the agreement, the doctor/hospital undertakes to treat the patient with the utmost care in treating and/or operating on the patient. The implied term "to exercise due care and skill" has its roots in the fiduciary relationship between the doctor/hospital and the patient in which the doctor/hospital is expected to exercise their professional skill with the utmost diligence and with the patient's interests being placed first. A further requirement in the formation of a contract between the doctor/hospital and patient is that there has to be an offer and acceptance. Unlike in commercial contract where conduct to achieve this end is distinct; in medical contracts this is not always discernable. Where, in written agreements such as the signing of admission forms or consent forms takes place, it is easy to determine that there has been offer and acceptance. The difficulty lies with unwritten agreements. This is where consent in whatever form serves as an aide. It has been stated before that consent is one of the material manifestations in bringing about consensus between the parties. In the modern world where rights issues are more prominent and the patient's consumer rights, as well as constitutional rights, receive greater emphasis, the patient's effective consent is fundamental consent, save for exclusions such as emergency situations

where this is not always possible, doctors and hospitals may incur liability in gigantic form.

The role of informed consent has become significant in the modern doctor/hospital-patient relationship. Besides creating and promoting a healthier relationship, informed consent serves as a tool to manage and respect the right to integrity and security as provided for by the Constitution and the common law. For informed consent, however, to be real, this has to be the imparting of appropriate information and the admission of knowledge of material risks of complications. The patient can then make an informed decision. Informed consent serves a twofold purpose, namely, it strengthens the doctor/hospital-patient relationship and it is essential for lawful intervention.

Once the formation requirements have been met and whatever formalities expected to be complied with has been adhered to, mutual obligations arise from the contractual relationship. These are then obligations, also referred to as duties, both the doctor/hospital and the patient are expected to carry out to comply with their contractual obligations. In Chapter Five the duties of the contracting parties will be considered. It needs to be stated here that one of the primary duties is for the doctor/hospital to exercise due care and skill which arises from their contractual relationship.

## Chapter 5

### The mutual duties and obligations between doctor/hospital and patient flowing from their contractual relationship

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#### 5.1 Introduction

This Chapter deals with the mutual duties and obligations between the doctor/hospital and the patient arising from, their contractual relationship. An investigation into the mutual duties, and obligations between the doctor/hospital and patient flowing from their contractual relationship is important for the purpose of the research undertaken with this thesis. The investigation reveals firstly, the nature of the degree of care and skill expected and undertaken by the doctor or hospital towards the patient. Secondly, the degree of care and skill expected of the doctor or hospital, towards the patient, is part of the primary or essential obligation undertaken by the doctor or hospital in terms of his/her/its contractual relationship with the patient. This is otherwise known in contractual terms, as the *essentialia* or *naturalia* of the contract. <sup>1</sup> It follows that the nature or essence of an agreement represents its end or purpose. <sup>2</sup> The *essentialia* in a contract between a doctor or hospital and patient is said to include, unless otherwise agreed, not to cure the patient or to guarantee a specific outcome, <sup>3</sup> but, an undertaking to examine, diagnose and treat the

<sup>1</sup> This concept stems from the Aristotelian notion that everything has a nature or essence from which certain obligation follow. See in this regard the writings of Gordley *The Philosophical Origins of Modern Contract Doctrine* (1991) 61, 67.

<sup>2</sup> Gordley (1991) 63, 102, 166.

<sup>3</sup> McQuoid-Mason and Strauss (1983) 114 Para 193; Strauss and Strydom (1967) 105-106; Strauss (1991) 40; Carstens and Pearmain (2007) 642ff; *Buls v Tsatsarolakis* 1976 (2) SA 891 (T) 193; *Kovasky v Krige* (1910) CTR 822; *Van Wyk v Lewis* 1924 (AD) 438 at 456.



patient against payment of compensation in the usual manner. To this end, the doctor or hospital in terms of the undertaking is to act with the degree of care and skill reasonably to be expected of an average practitioner in the field.<sup>4</sup> By acting in a careless, negligent manner, the doctor or hospital not only commits a breach of contract, but, is also liable in delict for loss suffered by the patient in consequence of negligent conduct.<sup>5</sup> Thirdly, the investigation will assist with the ultimate investigation into finding answers to the core issue, namely, whether an exemption clause or waiver, which purports to exempt a doctor or hospital from liability for lack of such care and skill, is contrary to the essence of the agreement and jeopardizes the attainment of the parties' basic purpose, *inter alia* an undertaking to employ a certain degree of care and skill.

The doctor/hospital's general duty towards the patient is discussed in this Chapter. This includes a brief discussion on whether the doctor/hospital is obliged to treat a patient. It also includes a discussion of the doctor/hospital's duty to inform the patient, which is concentrated on, but not restricted to, the nature, scope and consequences of the ailment or illness, the risks, danger, benefits and complications as well as alternatives to the proposed intervention. The discussion in this chapter also focuses on the nature of the doctor/hospital's duty to exercise due care and skill towards the patient and the doctor/hospital's obligation to execute the patient's instructions honestly, faithfully and with care. The exercise of due care includes the obligation that once the doctor/hospital commences treatment the treatment must be completed.

The relationship between, especially, the doctor and patient, is very much a personal one, in which intimate details are disclosed and discussed. For that reason a duty of confidentiality has been created which both the doctor/hospital and his/her/its staff must honour respect and obey. Besides the doctor/hospital acquiring duties and obligations from their contractual relationship, the patient similarly also receives obligations flowing from their relationship. The duty of the patient, besides paying the doctor/hospital professional fees, must make himself/herself available for treatment. The relationship between the medical practitioner/hospital/other healthcare provider and the patient is essentially a private

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<sup>4</sup> McQuoid-Mason and Strauss (1983) 115 Para 193, 204; Strauss and Strydom (1967) 106, 111, 262; Strauss (1991) 40; See further the discussion of Naude and Lubbe "Exemption clauses - A rethink occasioned by Afrox Healthcare Bpk v Strydom" *SALJ* (2003) 441 at 445; *Mitchell v Dixon* 1914 AD 519; *Van Wyk v Lewis* 1924 (AD) 438; *Castell v De Greef* 1993 (3) SA 501 (C).

<sup>5</sup> McQuoid-Mason and Strauss (1983) 114 Para 193; See also Carstens and Pearmain (2007) 619ff; Dada and McQuoid-Mason (2001) 22ff; Strauss (1991) 243; Claassen and Verschoor (1992) 13ff; Van Oosten (1996) Para 156; See further the discussion of Naude and Lubbe (2003) 445ff.

law matter, but it is very much governed by the law of obligations, in which the medical practitioner/hospital/healthcare provider is entrusted with a number of duties.

The first duty bestowed on the medical practitioner/hospital is to obtain the patient's consent before performing surgery or commencing treatment <sup>6</sup> as was previously discussed in Chapter 4. For consent however to be effective, and to comply with the requirements of informed consent, <sup>7</sup> the medical practitioner/hospital/other healthcare provider is obliged to make available to the patient sufficient information regarding the treatment and/or surgery, especially, the risks attached to the treatment and/or surgery. In this regard, although the medical practitioner/hospital/other healthcare provider is not obliged to disclose in detail all the complications, nevertheless, what is expected of him/her/it is to give the patient some general idea of the consequences, dangers and risks inherent in the operation and/or treatment, as well as, the nature and scope thereof. It is also indicated that the medical practitioner/hospital/other healthcare provider deals with alternatives (where available) and proposed interventions (where available).

The next duty involves the duration of the patient's treatment. Once the medical practitioner/hospital/healthcare provider undertakes to treat the patient, he/she/it must carry through and complete surgery and/or treatment, unless, the medical practitioner essentially makes other suitable arrangements or the patient is cured and does not require further

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<sup>6</sup> The rationale for this duty has been discussed differently by the South African legal writers. See Dada and McQuoid-Mason (2001) 7 who express the view that 'a patient has an absolute common law and constitutional right to his or her bodily integrity and security'. In this regard Section 12(1) of the *Constitution of South Africa Act* 108 of 1996 provides: "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.

See also Carstens and Pearmain (2007) 881. See further Claassen and Verschoor (1992) 57 who stresses the duty of a doctor to obtain the patient's consent when declaring 'obtaining a patient's consent is presently accepted as an unavoidable prerequisite for the performance of any form of medical treatment, either therapeutically or diagnostically in nature'. See also Strauss and Strydom (1967) 178; McQuoid-Mason and Strauss *LAWSA* (1983) Para191. Strauss (1991) 91 stress the common law right of a patient when he remarks: "Legally speaking, the basic ground of justification for medical treatment is consent. Contra Van Oosten *Encyclopaedia* (1996) 63 who stresses the point that, the prerequisite for the doctor obtaining the patient's consent lies in the contractual relationship between the doctor and patient. In this regard he states: "Since the relationship between doctor/hospital and patient is, generally speaking, a contractual one and a contract presupposes consensus ad idem between the parties, the patient's effective consent is fundamental to lawful medical intervention."

<sup>7</sup> The nature and scope of the information which must be discussed by the doctor or hospital staff should now be assessed in context of legislative requirements as stated in Section 6 of the *National Health Act* 61 of 2003. For a comprehensive discussion on the role of the doctrine of informed consent see Carstens and Pearmain (2007) 877ff.

treatment or the patient makes it impossible for the medical practitioner to continue treating the patient.<sup>8</sup>

The doctor/hospital's duty to exercise due care and skill, as previously stated, is a core value in the doctor/hospital-patient relationship. Of all the legal obligations which the doctor/hospital incurs arising from the doctor/hospital-patient contractual relationship, the doctor's or hospital's duty to exercise reasonable care and skill rank the highest in order of significance.

This could either take the form of an expressed term of the agreement where the agreement between the parties is in writing, alternatively, an implied term, when an oral agreement between the parties exists.<sup>9</sup>

As to what is meant by "due care and skill", it is generally accepted that, as the work of a doctor requires some form of skill, the standard required of especially, the medical practitioner, is upgraded, calling for an activity of expertise.<sup>10</sup> But what is required of the medical practitioner is not the highest possible degree of skill, but, rather, a reasonable and competent degree of skill expected at the time from members of the branch of the profession to which he/she belongs.<sup>11</sup> In other words, the medical practitioner, unless he

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<sup>8</sup> See Dada and McQuoid-Mason (2001) 6; See also Van Oosten Encyclopaedia (1996) 60 who state that "*where the doctor has taken charge of a patient a duty to complete the course of action embarked upon exists save in the following circumstances when the doctor will be relieved from the obligation to complete the case or to continue to treat the patient:*

- (a) *The patient has consented to the doctor's withdrawal from the case;*
- (b) *The patient ignores advice or instructions, or refuses or fails to pay the doctor's fees."*

<sup>9</sup> See Claassen and Verschoor (1992) 13 - 14 who advocate that "*.... the duty to exercise reasonable care and skill arises from the doctor/hospital's profession or vocation in that where the doctor possesses special knowledge or skill the law demands such degree of capability as can reasonably be expected from a practitioner or such profession or vocation.*" See also Strauss and Strydom (1967) 266 who adopts the same view. *Contra* Strauss "Duty to Care of Doctor towards Patient may arise independent of Contract." *SA Practise Management* Vol. 9 (1988) 18 in which the writer states that "*..... The duty of care in emergency situations may arise independent of any contract i.e., through medical ethics or depending on the circumstances in terms of a statutory duty.*"

<sup>10</sup> See Boberg *The Law of Delict* (1984) 346 who justifies the elevation of the standard of care as follows: "*Obviously the ordinary reasonable man test of negligence cannot be applied to an activity calling for expertise that the ordinary man does not possess. One cannot judge a surgeon's conduct by asking how a diligens paterfamilias would have operated, for either he would not have operated at all (which is most likely) or, if he would have operated (in some rare emergency), he would no doubt have done worse than even the most barbarous surgeon.*"

<sup>11</sup> See Van Oosten (1996) 82 who defines reasonableness in a medical context as: "*Not the highest possible degree of professional care and skill" or "the standard of the exceptionally able doctor but rather conduct with reasonable knowledge, ability, experience, care, skill and diligence is expected of the ordinary or average doctor endowed with the general level of knowledge, ability, experience, care, skill and diligence possessed and exercised by the*

guarantees to cure the patient, he is not expected to produce miracles. It is then accepted further, that doctors may make errors of judgement for as long as, such errors are reasonable.<sup>12</sup>

The degree of knowledge, experience, care and skill expected from that of a specialist as opposed to a general practitioner, is distinguished in, that if the doctor is a specialist, the test is that of the reasonable specialist in the branch of the profession to which he or she belongs, whereas, if the doctor is a general practitioner, the test is that of the reasonable practitioner.<sup>13</sup>

The degree of skill and care may very well be influenced by prevailing, universal and customary or usual practise of the profession, the place where the medical intervention or treatment is performed or given, the facilities available, etc.

Another duty of the medical practitioner/hospital/healthcare provider towards the patient is to carry out the patient's instructions honestly, faithfully and with care. The rationale behind this duty is said to arise from the medical practitioner's specialist expert knowledge, in which the medical practitioner finds himself in a relationship of particular trust with the patient. In other foreign jurisdictions this is often referred to as the fiduciary nature of the doctor-patient relationship, in which the medical practitioner is expected to act with the utmost good faith and loyalty and in which the medical practitioner cannot allow his/her personal interests to conflict with their professional duty. In this regard, the patient is

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*profession, bearing in mind that a doctor is a human being and not a machine and that no human being is infallible."*

<sup>12</sup> See Van Oosten (1996) 82 who in this regard suggests that "*Legal liability for an error of judgement will be dependant upon the reasonableness or unreasonableness of such error.*" Consequently the author suggests the following test to be applied: "*If it is a reasonable error of judgement that any doctor in the same position acting with the required care and skill could have made, no liability for negligence will attach. If it is an unreasonable error of judgement that no doctor in the same position acting with the required care and skill would have made, liability for negligence may follow.*" See in this regard also Claassen and Verschoor (1992) 20 who state: "*The law does not require that a practitioner be infallible in his conduct, and an error of clinical judgement will not constitute negligence where the proper standard of care has been followed. A practitioner may be aware, after the occurring of an incident that his judgement was wrong, but as long as his conduct was reasonable, he will not be held liable.*"

<sup>13</sup> See Van Oosten Encyclopaedia (1996) 83; See also Claassen and Verschoor (1992) 15 who opine that "*A specialist is required to employ a higher degree of care and skill concerning matters within the field of his speciality than a general practitioner.*" See also McQuoid-Mason and Strauss (1983) Par 199. *Contra* Gordon Turner and Price (1953) who formulate the attributes of the general practitioner and specialist as follows: "*The general practitioner should be reasonably skilled in all branches of medicine; the specialist should be particularly skilled in his speciality. But the skill required will, in accordance with general principle, be that of an average specialist, not that of an exceptionally able or gifted one.*"

placed first, in the time-honoured traditions of service, duty and honour.<sup>14</sup>

A further duty the medical practitioner is expected to carry out is the duty of confidentiality in which the medical practitioner is prohibited from revealing any information which ought not to be divulged regarding the ailments of a patient unless there is a ground for justification present. Both medical ethics and medical law dictate that the patient has a right to privacy and the medical practitioner is under a duty of confidentiality.<sup>15</sup>

There are, however, a number of grounds for justification in which the disclosure of information regarding the ailments of a patient may be justifiable. The grounds include consent, privilege, court order, litigation between the parties or disciplinary proceedings, statutory authority or statutory duty, and public interest or *boni mores*.

Besides the doctor/hospital incurring obligations arising from their contractual relationship with the patient, the patient also acquires certain duties, albeit very limited. In this regard the duty of the patient toward the medical practitioner/hospital/healthcare provider is limited to paying the fees charged for the medical services and, besides that, to also make himself/herself available for treatment whenever expected to do so, by the medical practitioner.<sup>16</sup>

Before the doctor/hospital's general duty towards the patient is discussed, it is of paramount importance to briefly draw a distinction between public health services involving

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<sup>14</sup> Carstens and Pearmain (2007) 321ff with reference to *Black's Law Dictionary* in which a fiduciary duty is defined as "a duty to act for someone else's benefit while subordinating one's personal interests to that of the other person. It is the highest standard of duty implied by law" supports the idea that in the doctor-patient relationship a fiduciary relationship can arise. The international writers have expressed strong views in favour of the fiduciary aspects of medical practice and in particular its usefulness in providing "a dynamic tool for reshaping the doctor-patient relationship as means to finding a proper balance in the discourse between patient and doctor." See Chapman (1984) 140 who describes the fiduciary relationship between the doctor and patient as "..... One in which the patient's interests are placed first and foremost in the time-honoured traditions of service, duty and honour."

<sup>15</sup> The foundation of its existence has been described by some writers as that founded in contract. See Van der Poel "Omissions and a Doctors Legal Duty to Warn Identifiable Sexual Partners of HIV Patients" *Responsa Meridiana* (1998) 21 who state that "It is an implied term of the agreement between the doctor and his patient or the nurse and the patient that the doctor and/or nurse will save for certain exceptional circumstances guarantee the patient's right to confidentiality." Other writers have founded the existence of this duty in the Hippocratic Oath which required the medical practitioner to preserve the confidence of patients. See Dada and McQuoid-Mason 2001 17.

<sup>16</sup> See Strauss and Strydom (1967) 115 - 119 "The patient must give his full co-operation by following the doctor's advice and instructions." See also McQuoid-Mason and Strauss (1983) 145 who share the view that where the patient however fails to give his co-operation or fail to carry out instructions "the practitioner cannot in any way force him to submit to treatment". This view is supported by Strauss and Strydom (1967) 116 who state: "The doctor may not subject the patient to treatment against his will. Any attempt to do so vitiates consent."

doctors employed by the hospitals, and doctors practising for their own account and private hospitals. In the former instance, health care services are in the main provided by public hospitals and medical practitioners in their employee, in terms of the state's constitutional obligation.<sup>17</sup> In the latter instance, the private hospital and private practitioners are independent entities whose existence is not state controlled but dependant upon the generation of own funds through the charging of professional fees to sustain their existence.

## 5.2 Doctor/Hospital's general duty towards the Patient

### 5.2.1 The Doctor/Hospital's duty to treat or not to treat

The question may be begged, is there an obligation in contract upon a doctor and/or hospital to treat a patient who knocks on their door? The answer lies in whether the patient consults a doctor in private practise, alternatively, whether the doctor is in the full time employ of a hospital or other health service provider in the public sector. Where a patient consults a doctor in private practise he enters into a contractual relationship with the doctor. When however, the patient presents for medical treatment (inclusive of an operation) by the staff at a hospital, be that a private or provincial hospital, a contractual relationship comes into being between the patient and the relevant hospital authority.<sup>18</sup> It is trite to say that, in private practise, where a patient consults a doctor or the staff at a private hospital the parties usually reach consensus and an agreement between the hospitals or doctor and the patient comes into being.<sup>19</sup> Contract is generally regarded in the private health care sector as the usual legal basis on which a patient obtains services from the provider, be that the doctor or the hospital or both.<sup>20</sup> This cannot be stated without question where a patient enters a public hospital, owned by provincial governments, in which health service delivery takes place in the public sector.<sup>21</sup> However, notwithstanding

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<sup>17</sup> The right to emergency medical treatment and the right to access to health care are set out in Sections 27(3) and 27(1) (b) and (c) of the Constitution, respectively.

<sup>18</sup> Dada and McQuoid-Mason (2001) 5; Strauss *SA Legal Handbook for Nurses and Health Personnel* (1992) 5; Christie (2001) 93-95; De Wet and Yates (1978) 307ff; Van Oosten (1996) 59; *Buls and Another v Tsatsarolakis* (1976) SA 85 (T).

<sup>19</sup> Van Oosten (1996) 63; Strauss and Strydom (1967) 105; Strauss (1991) 3; Claassen and Verschoor (1992) 116; Gordon et al (1953) 69-70.

<sup>20</sup> Carstens and Pearmain (2007) 413ff.

<sup>21</sup> Carstens and Pearmain (2007) 382ff highlights the objections lodged against the notion that a contractual relationship does exist between the patient and public providers. One of the major objections to the notion entails that the existence of a contractual relationship between patient and public provider promote the notion that the state is "selling" healthcare goods and services and patients are "purchasing" them. They counter this argument by stating that a contractual relationship does not necessarily imply a commercial objective. The writers also argue



the criticism against the notion that a contractual relationship exists between the patient and the public service provider, it appears that there is general acceptance that such a relationship does exist. One of the strongest arguments in support of such a notion is advanced by Carstens and Pearmain<sup>22</sup>, who believe that the concept of informed consent tends to strengthen the idea of a contractual relationship rather than delictual. The writers argue that the nature of informed consent includes, *inter alia*, the patient is to be fully informed of the nature of the proposed treatment, its consequences and the consequences of not having it, the risks associated with it is very much akin to the contractual principles of meeting of minds, contractual capacity are of involuntary reliance. This is further supported by the fact that the *National Health Act*<sup>23</sup> now regulates the nature and scope of the information which must be disclosed by every health care provider. In this regard the term "healthcare provider" is not restricted to public hospitals, but, includes a person providing health services in terms of any law *inter alia* the *Allied Health Professions Act*,<sup>24</sup> *Health Professions Act*,<sup>25</sup> the *Nursing Act*,<sup>26</sup> etc.

There is, however, a distinction in the application of the constitutional rights to access to healthcare services and the right not to be refused emergency medical services in the public sector, as opposed to the private sector. In the public sector, from a constitutional prospective, the state cannot refuse access to healthcare service to a person who has no alternatives available to them.<sup>27</sup> Private healthcare providers, unlike the state, as will be seen hereinafter, are not tasked by the Constitution with the progressive realisation of the right of access to healthcare services.<sup>28</sup>

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that a public provider-patient relationship is not always necessarily related to revenue generation or profit. Support for the argument that a contractual relationship may arise between a public hospital and patient can be found in the South African positive Law. In the case of *Behr v Minister of Health* 1976 (1) SA 891 (T) the court indicated that there was a general assumption that the relationship was at least 'quasi-contractual'. In the case of *Shields v Minister of Health* 1974 (3) SA 276 (RA) the court accepted the fact that there was a contractual relationship which had arisen between the *Minister of Health and Shields*. The most recent case to recognize that a contractual relationship between a public provider and a patient comes into being is that of *Administrator, Natal v Eduardo* 1990 (3) SA 581 (A).

<sup>22</sup> (2007) 404ff.

<sup>23</sup> 61 of 2003.

<sup>24</sup> 63 of 1983.

<sup>25</sup> 56 of 1974.

<sup>26</sup> 50 of 1978.

<sup>27</sup> Carstens and Pearmain (2007) 379ff.

<sup>28</sup> Carstens and Pearmain (2007) 380ff. The writers also argue that the question of how the constitutional rights of

It is also significant to note that private health establishments in South Africa, like public health establishments, are regulated by in terms of the *National Health Act*.<sup>29</sup> It should be noted further that although private practitioners and private hospitals operate on a for-profit basis, insofar as their ethical and professional norms and standards are concerned, they are regulated by the relevant legislation pertaining to their profession, which all are subordinate to the *National Health Act*.<sup>30</sup> Besides the *National Health Act*,<sup>31</sup> the *Health Professions Act*,<sup>32</sup> the *Nursing Act*,<sup>33</sup> etc, which regulate the medical profession, a code of ethical rules has also been drawn up in terms of the *Health Professions Act*<sup>34</sup> which promotes ethical conduct within the medical profession.<sup>35</sup> The enhancement of a strong commitment towards medical ethics and the maintenance of standards of good practise are significant in the quest to find answers to the core question undertaken by the research, namely, should one compromise ethics and standards to enforce exemption clauses or waivers.

Having investigated the role of the law of contract in health service delivery in the public sector as well as private sector and the influence of legislative measures, *inter alia*, the *National Health Act*<sup>36</sup> and *Code of Ethical Rules*,<sup>37</sup> the doctor's duty to treat or not to treat

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access to healthcare services and the right not to be refused emergency medical services apply in the context of the law of contract and to the private sector. Providers of healthcare services has so far not been canvassed in much significance except in the case of *Strydom v Afrox Healthcare Bpk* (2001) 4 ALL SA 618 (T) in which the ratio decidendi of the court in finding for the plaintiff was correct but not particularly well constructed.

<sup>29</sup> 61 of 2003; See also the discussion by Carstens and Pearmain (2007) 234ff who state that although the Act will eventually repeal its predecessor, the *Health Act* 63 of 1977, in its entirety, great parts of the latter Act and its regulations are currently still in operation.

<sup>30</sup> 61 of 2003; See the discussion by Carstens and Pearmain (2007) 234ff who regard the *National Health Act* as central to health legislation in South Africa (246). The Act also makes provision for the licensing of health establishments in both the public and private sectors in the form of certificates of need and allows the Minister of Health to prescribe minimum standards. This is yet to come into operation.

<sup>31</sup> 61 of 2003.

<sup>32</sup> 89 of 1997.

<sup>33</sup> 50 of 1978.

<sup>34</sup> 89 of 1997.

<sup>35</sup> Carstens and Pearmain (2007) 267 persuasively advance the argument that the code of ethics reflect the spirit of medical professionalism with reference to core ethical values and standards of good practice.

<sup>36</sup> 61 of 2003.

<sup>37</sup> These rules are made in terms of Section 49 of the *Health Professions Act* by the Health Professions Council. The rules were forwarded to the Minister of Health for approval in 2002 by virtue of GN717 dated 4 August 2006 but

will be looked at.

Private practitioners, legally speaking, can generally accept or refuse patients as they wish and there is no duty on them to treat people who are not already their patients.<sup>38</sup> An exception to the general rule is recognised and arises in emergency situations when they are expected to act. For example, a patient is brought to a doctor or hospital in an unconscious or semi-unconscious state.<sup>39</sup>

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has not been approved. See Carstens and Pearmain (2007) 205.

<sup>38</sup> See McQuoid-Mason *LAWSA* Vol. 17 (1983) Par 190 who state that the reason behind the foretasted rule is received from the general rule namely *"there is no liability for a mere omission in South African Law, unless there is a positive duty to act, or the circumstances are such that society would regard the failure to act as unlawful."* See also Dada and McQuoid-Mason 2001 6; *Contra* Strauss (1991) 3 who states that, generally, there is neither *"a duty upon a doctor to accept a patient neither is there a general right to treat any person."* This, the author argues is based on the principle that *"legally the doctor's right to operate or treat is based entirely on the patient's consent ....."* This Van Oosten Encyclopaedia (1996) 57 advocates are in line with the international view namely: *"In terms of the principle of freedom of contract a private practitioner is a 'free agent' who generally has 'the right to accept or refuse patients as he chooses'."* For that reason, as a general rule, doctors have neither a professional right, nor, generally speaking a legal duty to intervene medically.

<sup>39</sup> In these instances argue Dada and McQuoid-Mason (2001) 6 doctors *"are ethically required to assist people where the injured or ill person's life or health is seriously endangered, unless some other medical help is at hand or the physician's own life would be at risk. In such circumstances there may also be a legal duty to render medical assistance."* Apart from emergency situations, general practitioners may also assume a statutory duty over patients for example, vaccination, medical examination or treatment in own interest or for the purpose of public rights. See Van Oosten Encyclopaedia (1996) 57; See also Strauss (1991) 3; See further Regulation 13 under Sec 33(1) (j) of the Health Act 63 of 1977. This Act has now been repealed by the National Health Act 61 of 2003 although all the regulations have not been replaced which provides in certain circumstances doctors may have an ethical duty to treat or act in the best interests of the patient. This is particularly relevant today regarding HIV/AIDS patients. Refer to the Health Profession's Council of South Africa Guidelines for the Management of HIV/AIDS (2006). The management of patients with HIV infection or Aids required that *"ethically no doctor may refuse to treat any patient solely on the grounds that the patient is or may be HIV/AIDS infected."* The foretasted opinions regarding emergency treatment it is submitted, is consistent with Section 27(3) of the Constitution of the Republic of South Africa Act 108 of 1996 which provides *inter alia* that: *"No one may be refused emergency medical treatment."* As to what is meant by the term 'emergency', See *Soobramoney v Minister of Health, Kwazulu Natal* (1998) 1 SA 765 (CC) at 778 wherein the court defines an emergency as *"a dramatic, sudden situation or event which is of passing nature in terms of time" and not a chronic terminal illness such as kidney disease requiring dialysis."* See further Van Oosten Encyclopaedia (1996) 60 who also supports the notion that *"a duty to intervene exists in emergency situations."* The author states that *"a failure by a doctor to render assistance in cases of a bomb blast or traffic accident may render the doctor civilly and/or criminally liable."* See further Strauss (1991) 3, 90, 254; See also The Health Profession's Council of South Africa's policy ruling, in terms of which a medical practitioner is obliged, in cases of emergency, to render assistance at all times. The South African Courts have in the past also voiced their opinion regarding the duty of the doctor towards his patient. See *Ex Parte Dixie* 1950 (4) 748 (W) at 751 where Millen J held with reference to a surgical operation, that as a matter of law: *"Such an operation cannot lawfully be performed without the consent of the patient, or, if he is not competent to give it, that of some person in authority over his person. The fact that he is a patient in this hospital does not entitle those in charge of it to perform any surgical operations upon him which they may consider beneficial. They would only be justified in performing an operation without consent where the operation is urgently necessary and cannot with due regard to the patient's interests, be delayed."* In *Stoffberg v Elliot* (1922) OPD 148 at 149 Watermeyer J with regard to the best interests of the patient stated: *"Now, in so far as the question of law is concerned, I must direct you that a man, by entering a hospital does not submit himself to such*

State doctors and medical officers on the other hand, may not refuse to treat patients whom they are bound to treat in terms of their contracts of employment, or under a statutory duty, as well as constitutional obligations imposed on them.<sup>40</sup>

Once the private practitioner has been consulted and he or she has undertaken to treat the patient, the practitioner assumes the following duties:

### 5.2.2 The Duty to Complete Treatment once Commenced

The doctor must carry through and complete treatment once commenced unless:

- (1) The doctor can leave it in the hands of another competent practitioner;
- (2) The doctor issues sufficient instructions for further treatment;
- (3) The patient is cured or does not require further treatment;
- (4) The patient refuses further treatment or insists on being discharged from hospital, provided the patient is mentally capable of doing so; and
- (5) The doctor gives the patient reasonable notice that he or she intends to discontinue his or her practice, in which case the doctor should ensure that other facilities are

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*surgical treatment as the doctors in attendance upon him may think necessary. He may submit himself for medical treatment, but I am not going into that; I am going to attempt to define the exact limit of medical treatment, because they do not seem to me to be material in this case, but he does not consent to such surgical treatment as the doctor may consider necessary. By going into hospital, he does not waive or give up his right of absolute security of the person; he cannot be treated in hospital as a mere specimen, or as an inanimate object which can be used for the purposes of vivisection; he remains a human being and he retains his right of control and disposal of his own body; he still has the right to say what operation he will submit to, and, unless his consent to an operation is expressly obtained, any operation performed upon him without his consent is an unlawful interference with his right of security and control of his own body, and is a wrong entitling him to damages if he suffers any."*

In *Castell v De Greef* 1994 (4) SA 408 Ackermann J expressed the following harsh word when looking at the best interests of the patient: "I cannot conceive how the 'best interests of the patient' (as seen through the eyes of her physician or the entire medical profession, for that matter) could justify a mastectomy or any other life-saving procedure which entailed a high risk of the patient losing a breast. Even if the risk of breast-loss were insignificant, a life-saving operation which entailed such risk would be wrongful if the surgeon refrains from drawing the risk to his patient's attention, well knowing that she would refuse consent if informed of the risk. It is, in principle, wholly irrelevant that her attitude is, in the eyes of the entire medical profession, grossly unreasonable, because her rights of bodily integrity and autonomous moral agency entitle her to refuse medical treatment. It would, in my view, be equally irrelevant that the medical profession was of the unanimous view that, under these circumstances, it was the duty of the surgeon to refrain from bringing the risk to his patient's attention."

<sup>40</sup> See Dada and McQuoid-Mason (2001) 6 who express the view that "a casualty official at a hospital is obliged to treat patients brought in for treatment." See also McQuoid-Mason and Strauss (1983) Par 190; Carstens and Pearmain hold the view that in South Africa, public health services are traditionally the safety net into which all patients can fall, including those within the private sector who have exhausted their medical scheme benefits or whose membership of a scheme has been terminated for some reason or another. From a constitutional perspective the writers also hold the view that "the State cannot refuse access to healthcare service to a person who has no alternatives available to them." They also opine that "this is a base line which materially alters the position of public providers of healthcare services in relation to their private counterparts."

available.<sup>41</sup>

In the latter instance, it is submitted, the doctor should issue full instructions for further treatment and indicate his or her willingness to consult with the practitioner who takes over his duties (if any) in treating the patient.<sup>42</sup>

### 5.2.3 The Duty to Obtain the Patient's Consent

A doctor generally has no right to treat a patient unless the patient consents to such treatment.<sup>43</sup>

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<sup>41</sup> See Dada and McQuiod-Mason (2001) 6; See also Van Oosten Encyclopaedia (1996) 60. See also Strauss and Strydom (1967) 113-114. Although the blacklisting of patients who have a record of bad debt may under certain circumstances be legally permissible. See Strauss (1991) 63-64 *Contra Todhill v Gordon* 1930 WLD 99. With regard to case law placing a duty to complete treatment once commenced see *Kovasky v Krige* (1910) 20 CTR 822, a case which involves the treatment of a nine month old infant for a haemorrhage following a circumcision operation, the Plaintiff alleged that the doctor was negligent in that the infant contracted gangrene after the physician allegedly withdrew from the case before the bleeding stopped. It was also alleged that the doctor did not return timeously after being called. Dismissing the Plaintiff's claim on behalf of the infant, Buchanan J said: "..... it is proved that though the defendant was not long in attendance, he did remain until the haemorrhage had ceased. He remedied the evil which he had been called in to remedy. The next allegation is that he did not return within a reasonable time, not until he had been called upon to do so. I cannot see that there was any necessity for him to return: he had been called in to stop the haemorrhage, and he had done so. As a rule, doctors do not pay visits after they have done their work, unless they are especially asked to do so, on behalf of the patients." See also the case of *Webb v Isaac* (1915) E.D.L. 273 the defendant set and splinted the patient's leg on a remote farm. He did not visit the patient again, being satisfied with reports given to him by a third party on the progress of the case, and being unwilling to "run up the fees" against the third party, who had guaranteed his remuneration and expenses. The leg shortened and twisted, as a result of which it became necessary to have it re-broken and re-set. The Court felt that he had been culpable in not re-attending the patient, but was not prepared to hold him liable, as it was satisfied that such re-attendance would not in the circumstances have affected the result in any way. See further Claassen and Verschoor (1992) 117 regarding the position where the treatment takes the form of a therapeutic series. The authors caution that "*the practitioner may not withdraw himself from the treatment before the completion of the whole process.*" According to the authors "*withdrawal in this instance will expose the doctor to contractual claims and he may also be held liable delictually where the patient has suffered personal injuries as a result of the culpable interruption of treatment.*" See also Strauss and Strydom (1967) 113.

<sup>42</sup> See Gordon, Turner and Price (1953) 123.

<sup>43</sup> A more detailed discussion on the different forms of consent and the requirements thereof follows hereinafter. For the legal writings see Dada and McQuiod-Mason (2001) 7. Van Oosten Encyclopaedia (1996) 63 who stresses the point that the prerequisite for the doctor obtaining the patient's consent lies in the contractual relationship between the doctor and patient. In this regard he states: "*Since the relationship between doctor/hospital and patient is, generally speaking, a contractual one and a contract presupposes consensus ad idem between the parties, the patient's effective consent is fundamental to lawful medical intervention.*" This requirement is stringently applied so much so that Van Oosten Encyclopaedia (1996) 63 remarks: "*The legal consequences of a medical intervention performed without the patient's effective consent are that the doctor may incur liability for breach of contract, civil or criminal assault (a violation of bodily integrity) or negligence as the case may be,*" and further "*this applies irrespective of whether or not the intervention was administered with due care and skill and eventually proves to have been beneficial to the patient.*" The ratio behind the latter thinking according to Van Oosten Encyclopaedia (1996) 64 lies in the fact that: "*The violation perpetrated by the doctor who performs the wrongful or unlawful intervention being one against the patient's physical integrity or dignitas/privacy rather than one against his or her health.*" See also Carstens and Pearmain (2007) 875 who holds the view that social

#### 5.2.4 The Duty to Inform the Patient

To be legally valid, consent must be based on substantial knowledge concerning the nature and effect of the act consented to. This is generally referred to as informed consent.<sup>44</sup> The

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development as well as constitutional development in South Africa were instrumental to the demand for free and informed decision-making. It is especially Chapter 2 of the Bill of Rights in the South African Constitution which contributed to the increased demand for bodily integrity, self determination, privacy, equality, information and administrative justices. For the case law South Africa, apart from the academic writings, has a high history of case law in which the patient's right to his or her bodily integrity and security has been protected. As far back as 1923 the question of implied consent to a surgical operation arose in the well-known case of *Stoffberg v Elliot* 1923 C.P.D. 148 in which the Plaintiff entered a hospital, conscious, and was subjected to a surgical operation resulting in his penis being removed during the operation, the surgeon claiming that the patient had had an incurable cancer of the penis hence the necessity to operate. In his summing up to the jury, Watermeyer J. said: "*Now, the declaration in this case alleges an unjustified, unexcused, and unconsented to interference: the plea admits an interference, but it says there was consent to the operation, but not an express consent, a contract implied by the fact that the man went into the hospital; it says the plaintiff was admitted for treatment, and thereby consented to undergo such surgical and medical treatment as was immediately necessary, and here we come really to the first issue between the parties. It is a question partly of fact and a question partly of law whether there was an implied consent to undergo such surgical treatment as was considered reasonable and necessary by the doctor. Now, in so far as the question of law is concerned, I must direct you that a man, by entering a hospital, does not submit himself to such surgical treatment as the doctors in attendance upon him may think necessary; he may submit himself for medical treatment, but I am not going into that. I am not going to attempt to define the exact limits of medical treatment, because they do not seem to me to be material in this case, but he does not consent to such surgical treatment as the doctor may consider necessary. By going into hospital, he does not waive or give up his right of absolute security of the person; he cannot be treated in hospital as a mere specimen, or as an inanimate object which can be used for the purposes of vivisection. He remains a human being, and he retains his rights of control and disposal of his own body; he still has the right to say what operation he will submit to, and unless his consent to an operation is expressly obtained, any operation performed upon him without his consent (sic) is an unlawful interference with his right of security and control of his own body, and is a wrong entitling him to damages if he suffers any.*" In a more recent judgement of Ackerman J in *Castell v De Greef* 1994 (4) SA 408 at 420-421 the judge echoed the same sentiment but with respect in more modern terms: "*It is clearly for the patient to decide whether he or she wishes to undergo the operation, in the exercise of the patient's fundamental right to self-determination. A woman may be informed by her physician that the only way of avoiding death by cancer is to undergo a radical mastectomy. This advice may reflect universal opinion and may be, in addition, actually correct. Yet, to the knowledge of her physician, the patient is, and has consistently been, implacably opposed to the mutilation of her body and would choose death before the mastectomy. I cannot conceive how the 'best interests of the patient' (as seen through the eyes of her physician or the entire medical profession, for that matter) could justify a mastectomy or any other life-saving procedure which entailed a high risk of the patient losing a breast. Even if the risk of breast-loss were insignificant, a life-saving operation which entailed such risk would be wrongful if the surgeon refrains from drawing the risk to his patient's attention, well knowing that she would refuse consent if informed of the risk. It is, in principle, wholly irrelevant that her attitude is, in the eyes of the entire medical profession, grossly unreasonable, because her rights of bodily integrity and autonomous moral agency entitle her to refuse medical treatment. It would, in my view, be equally irrelevant that the medical professor was of the unanimous view that, under these circumstances, it was the duty of the surgeon to refrain from bringing the risk to his patient's attention.*" See also *Layton and Layton v Higginson* 1944 SR 48, 50; *Lampert v Hefer* 1955 (2) SA 507 (A) 508; *Esterhuizen v Administrator Transvaal* 718 ff; *S v Sikunyana* 1961 (3) SA 549(E), 551; *Richter v Estate Hammann* 232; *Burger v Administrator Kaap* 489; *S v Kite* 1994 (1) SACR (E) 14; *S v Binio* 1993 (2) SACR 553 (C) 561 - 562; *Fourie v Wilson* 1993 (N) (unreported, discussed by Strauss SA 1994 (2) SAPM (O).

<sup>44</sup> See McQuoid-Mason and Strauss *LAWSA* (1983) Volume 17 Par 196; See also Gordon, Turner and Price (1953) 157 who describe the substantial knowledge as '*The patient should have been left in no doubt as to the exact nature of the operation proposed.*' See also Claassen and Verschoor (1992) 62 who define informed consent as '*essential knowledge regarding the nature and effect of the proposed treatment.*' Informed consent is also



rationale for the existence of this doctrine has been described by our academic writers as ranging from the endorsement of patient autonomy as a fundamental right and the rejection of medical paternalism<sup>45</sup> to the scientific assessment of the case arising from the complexity of symptoms in which the doctor, on the basis of his knowledge, skill and experience plays a leading roll.<sup>46</sup>

The question may be begged, what information does the doctor have to disclose to the patient? The answer lies in both the common law writings as well as legislation. Although

described by Van Oosten Encyclopaedia (1996) 67 - 68 as the `knowledge and appreciation' gained by the patient through `appropriate information' parted by the doctor as expert. See also Strauss (1991) 6; Dada and McQuoid-Mason (2001) 13; For other writings see Burchell "Informed Consent - Variations on a familiar theme" 1986 *M&L* 293; Van den Heever "The patients right to know" 1995 *De Rebus* 53; Carstens (1996) 430; Pearmain (2004) 742ff; Carstens and Pearmain (2007) 875ff.

- <sup>45</sup> See Van Oosten Encyclopaedia (1996) 68 - 69 who describes the purpose of informed consent as follows:
- (a) to ensure the patient's right to self-determination and freedom of choice; and
  - (b) to encourage rational decision-making by enabling the patient to weigh and balance the benefits and disadvantages of the proposed intervention in order to come to an enlightened choice either to undergo or refuse it.

See also Carstens and Pearmain (2007) 877 with reference to the positive law including the cases of *Stoffberg v Elliott* 1923 CPD 148; *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T); *Castell v De Greef* 1994 (4) SA 408 (C); *Broude v McIntosh* 1998 (3) SA 60 (SCA); *Jacobson v Carpenter-Kling* 1998 (T), unreported; *Oldwage v Louwrens* (2004) 1 ALL SA 532 (C); *McDonald v Wroe* unreported case no 7975/03 (CID); *Louwrens v Oldwage* 2008 (2) SA 161 (SCA) comments as follows on the rationale for the existence of the doctrine, namely, informed consent being the foundation or core of the patient/doctor relationship, emanating from the law of obligations and underscored by ethical considerations determines the atmosphere between doctor and patient i.e., whether there is a harmonious or acrimonious relationship. But the writers also spell out that the application of the doctrine in practice is often fraught with controversy more so because of the attitude of the physician who resist the patient autonomy model and clings to the paternalistic models. See page 877. Insofar as the positive law is concerned it is especially the more recent cases starting with *Castell v De Greef* 1994 (4) SA 408 which can be regarded as the *locus classicus*, which have now entrenched patient autonomy after importing the doctrine of informed consent into South African medical law. Since ousting medical paternalism in favour of patient autonomy and treating lack of informed consent as an issue of assault and not negligence, the Supreme Court of Appeal also had an opportunity in *Broude v McIntosh* 1998 (3) SA 60 (SCA) to revisit the application of the doctrine as stated in *Castell v De Greef*. Although the court questioned obiter the conceptual soundness to regard lack of informed consent as an assault, the court did not overturn the decision in *Castell v De Greef*. In two subsequent decisions in the Transvaal Provincial Division in *Jacobson v Carpenter-Kling* 1998 (TPD) Unreported and *Pop v Revelas* 1999 (WLD) unreported, reliance was placed on the Castell decision with regard to patient autonomy. The application, nature and scope of the doctrine of informed consent was recently restated in the decision of the Cape Provincial Division of the High Court in *Oldwage v Louwrens* (2004) 1 ALL SA 532 (C). The decision of Yekiso J was subsequently taken on appeal. In the case of *Louwrens v Oldwage* 2006 (2) SA 161 (SCA) the court questioned the decision of Yekiso J in the Oldwage case that a lack of informed consent constitutes an assault. The court however, did not overrule the decision of Castell. More recently, in the case of *McDonald v Wroe* Unreported case No 7975/03 (CPD) the court again placed reliance on the principles enunciated in *Castell v De Greef* to find that the plaintiff's right to bodily integrity was violated as she was subjected to surgery without her informed consent.

- <sup>46</sup> See Strauss (1991) 6. See also McQuoid-Mason *LAWSA* (1983) Volume 17 Par 196 who expresses the view that "Because of the technical nature of most forms of medical treatment and surgical operations, there is a duty upon the practitioner to inform the patient." *Contra* Claassen and Verschoor (1992) 58 who is critical as such "vocational right" may lead to a denial of a patient's right to self-determination and page 63 `demanding from practitioners to obtain a patient's informed consent, the doctrine attempts to promote intelligent decision-making'.

the requirements for the disclosure of information, to the patient by the doctor, have for many years been regulated by the common law and positive law, more recently, with the passing of the *National Health Care Act* <sup>47</sup> the nature and scope of the information which must be disclosed by the doctor should now be assessed in the context of legislative requirements as provided in Section 6 of the Act. <sup>48</sup>

It is suggested that in terms of the common law and legislative requirements, the doctor is obliged to give the patient a general idea, in broad terms <sup>49</sup> and in a lay person's language,

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<sup>47</sup> 61 of 2003.

<sup>48</sup> For a discussion on the common law requirements and legislative provisions on the information which need to be discussed see Carstens and Pearmain (2007) 883ff.

<sup>49</sup> For the legal writings see Van Oosten Encyclopaedia (1992) 69 - The author suggests that *'there being no obligation to disclose in detail all the complications that may arise.'* See also Strauss Doctor, Patient and The Law (1991) 6 *'who states that it may be impractical to attempt giving the patient a general indication in layman's language of the diagnosis.'* For that reason, the *'full diagnosis must be given only where the patient stipulates this as a condition to giving his consent to an operation or treatment.'* In this regard Claassen and Verschoor (1992) 63 cautions that *'it is totally impractical to expect from a practitioner to convey to a patient his complete expert knowledge and insight.'* See also McQuoid-Mason and Strauss (1983) *LAWSA* Par 196 who expresses the view that *'a practitioner need not point out meticulously all the conceivable complications which may arise'*. See also the legislative provisions in terms of the National Health Act 61 of 2003 and the discussion by Carstens and Pearmain (2007) 888ff. For case law, although there is a scarcity of South African case law on the question to what extent a medical practitioner is obliged to furnish patients with information about the intervention or treatment, there are at least some indications in a number of court decisions of the scope of information required from medical practitioners. In this regard, Wessels JA in *Lymbery v Jefferies* 1925 (AD) 236 at 240, remarked: *"All the surgeon is called upon to do is to give some general idea of the consequences. There is no necessity to point out meticulously all the complications that may arise."* In the same view, but slightly more specific Nesor J in *Rompel v Botha* (1953) (T) (Unreported) and discussed in *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 T 718) stated: *"There is no doubt that a surgeon who intends operating on a patient must obtain the consent of the patient. In such cases where it is frequently a matter of life and death I do not intend to express any opinion as to whether it is the surgeon's duty to point out to the patient all the possible injuries which might result from the operation, but in a case of this nature, which, may have serious results to which I have referred, in order to effect a possible cure for a neurotic condition, I have no doubt that a patient should be informed of the serious risks he does run. If such dangers are not pointed out to him then, in my opinion, the consent to the treatment is not in reality consent - it is consent without knowledge of the possible injuries. On the evidence defendant did not notify plaintiff of the possible dangers, and even if plaintiff did consent to shock treatment he consented without knowledge of injuries which might be caused to him. I find accordingly that plaintiff did not consent to the shock treatment."* Endorsing the remarks made by Nesor J in *Rompel v Botha* supra Bekker J in *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) emphasized that doctors owed a duty to patients of having to inform them prior to any operation or treatment, of all the consequences, dangers and details of the risks inherent in the operation or treatment when he remarked at 721 as follows: *"I do not pretend to lay down any such general rule; but it seems to me, and this is as far as I need go for purposes of a decision in the present case, that a therapist, not called upon to act in an emergency involving a matter of life or death, who decides to administer a dosage of such an order and to employ a particular technique for that purpose, which he knows beforehand will cause disfigurement, cosmetic changes and result in severe irradiation of the tissues to an extent that the possibility of necrosis and a risk of amputation of the limbs cannot be excluded, must explain the situation and resultant dangers to the patient - no matter how laudable his motives might be - and should he act without having done so and without having secured the patient's consent, he does so at his own peril."* In a more recent judgement and commenting on the doctor's duty to warn their patients, prior to operating on the plaintiff, of the natural risks and complications which might flow from such operation, and of any specific alternative procedures which might be

<sup>50</sup> of the nature, <sup>51</sup>, scope, <sup>52</sup>, consequences, <sup>53</sup> risks, dangers, complications, <sup>54</sup> benefits,

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followed in order to minimize, reduce or exclude such risks or complications Ackerman J in *Castell v De Greef* 1994 (4) SA 408 at 416 - 417 commenting on what Scott J stated in the judgement in the Court a Quo namely:

"(a) *medical practitioner undoubtedly has a duty in certain circumstances to warn his patient of the risks involved in surgery or other medical treatment.*"

"(b) *The difficulty is to determine when that duty arises and what the nature and extent of the warning* He dissents from Scott J's view when he held that a doctor is obliged to warn the patient consenting to medical treatment of a material risk inherent in the proposed treatment. He goes on to justify the recognition of the doctrine of informed consent when he commented: *"It is important, in my view, to bear in mind that in South African Law (which would seem to differ in this regard from English Law) consent by a patient to medical treatment is regarded as falling under the defence of volenti non fit injuria, which would justify an otherwise wrongful delictual act. (See, inter alia, Stoffberg v Elliott 1923 CPD 148 at 149- 5-; Lymbery v Jefferies 1925 AD 236 at 240; Lampert v Hefer NO 1955 (2) SA 507 (A) at 508; Esterhuizen's case supra at 718 -22; Richter's case supra at 232 and Verhoef v Meyer 1975 (TPD) and 1976 (A) (unreported), discussed by Strauss (op cit at 35-6))"*It is clearly for the patient to decide whether he or she wishes to undergo the operation, in the exercise of the patient's fundamental right to self-determination." The court continues its justification when Ackerman J at 425 states: *"In the South African context the doctor's duty to disclose a material risk must be seen in the contractual setting of an unimpeachable consent to the operation and its sequelae (see Van Wyk v Lewis 1924 AD 438 at 451; Correia v Berwind 1986 (4) SA 60 (ZH) at 63 and Verhoef v Meyer (supra at 32 et seq of the unreported Transvaal Provincial Division judgement and 26-9 of the unreported Appellate Division judgement.)* As van Oosten (op cit at 14-5) points out: *"South African law generally classifies volenti non fit injuria, irrespective of whether it takes the narrower form of consent to a specific harm or the wider form of assumption of the risk of harm, as a ground of justification (regverdigingsgrond) that excludes the unlawfulness or wrongfulness element of a crime or delict."*For consent however to operate as a defence the court lay down the following requirements:

"(a) *The consenting party must have had knowledge and been aware of the nature and extent of the harm or risk;*

(b) *The consenting party must have appreciated and understood the nature and extent of the harm or risk;*

(c) *The consenting party must have consented to the harm or assumed risk;*

(d) *The consent must be comprehensive, that is extending to the entire transaction, inclusive of its consequences."* As to what constitutes a material risk the court formulates the test as follows: *"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 he particular patient, if warned of the risk, would be likely to attach significance to it."*

<sup>50</sup> It has been held before that there is no obligation on the doctor to educate the patient up to the standard of the doctor's medical knowledge. See *Castell v De Greef* (1993) 518. However, the patient must understand. See Carstens and Pearmain (2007) 884 on the discussion of Section 6 of the National Health Care Act 61 of 2003.

<sup>51</sup> As to the nature of the disclosure it was touched on very briefly by Watermeyer J when instructing the jury in *Stoffberg v Elliott* 1923 CPD 148 when he comments: *"A man, by entering a hospital, does not submit himself to such surgical treatment as the doctors in attendance upon him may think necessary; he may submit himself for medical treatment, but I am not going into that; I am not going to attempt to define the exact limits of medical treatment, because they do not seem to me to be material in this case, but he does not consent to such surgical treatment as the doctor may consider necessary. By going into hospital, he does not waive or give up his right of absolute security of the person; he cannot be treated in hospital as a mere specimen, or as an inanimate object which can be used for the purposes of vivisection; he remains a human being, and he retains his rights of control and disposal of his own body; he still has the right to say what operation he will submit to, and, unless his consent to an operation is expressly obtained, any operation performed upon him without his consent is an unlawful interference with his right of security and control of his own body, and is a wrong entitling him to damages if he suffers any."* Section 6 of the National Health Act 61 of 2003 provides that the physician is obliged to disclose the nature, scope, consequences, risks, dangers, complications and benefit to the patient.

<sup>52</sup> Dealing with the scope of the measures and proposed treatment especially where radical treatment is proposed, it

disadvantages and prognoses <sup>55</sup> of, as well as the alternatives <sup>56</sup> to, the proposed intervention. <sup>57</sup>

#### 5.2.5 The Doctor's/Hospital's duty to exercise due care and skill

As was seen earlier a contract normally gives rise to a complex of rights and duties, of which the expressed or implied contractual duty to exercise due care and skill, is but one. Of the legal obligations that arises from the doctor/hospital-patient contractual relationship, the doctor's or hospital's duty to exercise reasonable care and skill rank amongst the forerunners. <sup>58</sup> This duty may take the form of an express term of the agreement between

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was held in *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) at 720 in which the doctor had failed to disclose the fact that, unlike previous treatments consisting of superficial radiotherapy, the proposed treatment involved radical radiotherapy that such conduct constitutes an assault on the patient arising from an absence of consent.

<sup>53</sup> Doctors have also been held liable in actions for damages based on their negligence in failing to disclose to the patient that they had caused harm to the patient where they had taken remedial action arising from their negligent conduct. This contentious issue received the attention of our courts in *Prowse v Kaplan* 1933 EDL 257 in which a dentist was held liable for his conduct in failing to disclose to the patient that he had fractured her jaw in an attempt to rectify a dislocation which he had caused during a previous operation upon her. In other cases however *inter alia*, *Allott v Paterson and Jackson* 1936 SR 221 222 224, the court refused to uphold the contention that the dentist was negligent in not warning the patient that difficulties might be experienced in extracting his tooth, in order that a suitable anaesthetic might be administered.

<sup>54</sup> Doctors were held liable in a number of cases where patients were not warned by doctors against potential risks, dangers and/or complications. In this regard see *Lymbery v Jefferies* 1925 AD 236 concerning sterility and burns as a result of radiotherapy; *Rompel v Botha* 1953 (A bone fracture as a result of electro-convulsive shock treatment); *Esterhuizen v Administrator Transvaal* 1957 (3) SA 410 T 719 concerning severe irradiation and ulceration of tissues, disfigurement, necrosis, cosmetic changes and amputation of limbs; *Verhoef v Meyer* 1953 (T) concerning an operation to remedy a retinal detachment; *Richter v Estate Hammann* (1976 (3) ST 226 (C) (loss of control of the bladder and bowel, loss of sexual feeling and loss of power in the right leg and foot); *Castell v De Greef* (1994) (discoloration of the areola, necrosis of the tissues, a discharge with an offensive odour, a staphylococcus aureus infection, pain, embarrassment and trauma, and further surgery to repair the damages). This requirement is now regulated by Section 6 of the National Health Act 61 of 2003.

<sup>55</sup> See *Castell v De Greef* (1994) (c) on the doctor's duty to inform the patient of the necessity of subsequent intervention. This requirement is also regulated by Section 6 of the National Health Act 61 of 2003.

<sup>56</sup> With regard to alternatives which may include no treatment at all see *Castell v De Greef* (1994) (C).

<sup>57</sup> See Van Oosten (1989) 449 - 450 wherein the learned author suggests that; "*The information given to the patient regarding proposed intervention shall include: the available alternatives to the proposed intervention, the urgency and gravity of the proposed intervention; the degree of risk or danger that the proposed intervention entails .....*". This requirement is now regulated by Section 6 of the National Health Act 61 of 2003

<sup>58</sup> For legal writings see Strauss and Strydom (1967) 266; McQuoid-Mason and Strauss LAWSA (1983) Par 189; Gordon, Turner and Price (1953) 110; Carstens "Prophylaxis against medical negligence: A Practical approach May (1988) *De Rebus* 345; Van Dokkum "Medical Malpractice in South African Law" (1996) *De Rebus* 792; Van Oosten Encyclopaedia (1996) 54 - 55; Strauss (1991) 72 - 73; McKerron *The Law of Delict* (1971) 38; Van Oosten "Professional Medical Negligence in South African Legal Practise" *Medicine and Law* (1986) 18 - 19; Dada and McQuoid-Mason (2001) 22 - 23; See further Carstens and Pearmain (2007) 364. For case law see the

them which is normally included in a consent form. It may never even be discussed between them. Even in the absence of an express agreement between the doctor/hospital and patient, an implied term to exercise due care, as such, comes into being as soon as the contract between the doctor/hospital and the patient is concluded.<sup>59</sup>

As to the meaning of 'due care and skill', our legal writers, as well as our courts, have over decades or so given meaning to the term. It is accepted generally amongst legal writers that, as the work of a doctor requires some form of skill, the standard or care required of the medical practitioner is upgraded, in that, the medical practitioner engages in an activity calling for expertise.<sup>60</sup>

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following South African cases in which our courts have recognised the doctor's duty to exercise reasonable care and skill: *Mitchell v Dixon* 1914 AD 519; *Van Wyk v Lewis* 1924 AD 438; *Allott v Paterson and Jackson* 1936 SA 221; *Kovalsky v Krige* (1910) 20 CTR 822; *Coppen v Impey* 1916 CPD 309; *Buls v Tsatsarolakis* 1976 (2) SA 891 (T), 893; *Applicant v Administrator Transvaal* 1993 (4) SA 733 (W); *Collins v Administrator Cape* 1995 (4) SA 73 (C); *Clinton-Parker v Administrator Transvaal* (1996) (2) SA 37 (W). See also *Lee v Schönberg* (1877) 7 BUCH 136; *Webb v Isaac* 1915 EDL 273, 276, 278, 279; *Dale v Hamilton* 1924 WLD 184, 199, 200, 203; *Byrne v East London Hospital Board* 1926 EDL 128, 158; *Ex parte Rautenbach* 1938 SR 150, 151; *R v Van Schoor* 1948 (4) SA 349 (C) 350, 352; *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) 723 - 724, 726; *Dube v Administrator Transvaal* 1963 (4) SA 260 (T) 266 - 267, 268; *S v Mkwetshana* 1965 (2) SA 493 (N) 496 - 497; *Richter v Estate Hammann* 1976 (3) SA 226 (C) 232; *Blyth v Van den Heever* 1980 (1) SA 191 (A) 221; *Magware v Minister of Health* 1981 (4) SA 472 (Z) 476 - 477.

<sup>59</sup> For legal writings see Claassen and Verschoor (1992) 13 - 14; For a comprehensive discussion on the tacit or implied terms in healthcare contracts see Carstens and Pearmain (2007) 362ff.

<sup>60</sup> For legal writings see Boberg (1984) 346. See also McKerron (1971) 38; Neethling Potgieter and Visser (1996) 133; Van der Merwe and Olivier (1989) 142; Van der Walt (1979) 70. See further Van Oosten (1996) 81 - 82 who formulates the position as follows: "*The criteria used in measuring the conduct of the medical practitioner is no longer an objective test in which the hypothetical or fictitious reasonable person sets the standard but has shifted to a more subjective test in which the reasonable doctor in the same position as the individual doctor set the standard.*" See also Carstens and Pearmain (2007) 364. For case law see one of the first decisions of *Lee v Schönberg* (1877) 7 BUCH 136 the Cape High Court relying heavily on an English decision of *Lampher v Phipos* (1835) 8 C&P 475 laid down the following general rule: "*There can be no doubt that a medical practitioner, like any professional man, is called upon to bring to bear a reasonable amount of skill and care in any case to which he has to attend, and that where it is shown that he has not exercised such skill and care, he will be liable in damages.*" In a later decision of *Kovasky v Krige* (1910) 20 822 CTR Sir John Buchanan also relied upon the English decision of *Lampher v Phipos* (1835) 8 C&P 475 when he remarked: "*The principles there laid down, have been applied in this court, and with them I entirely agree. As to capacity, Chief Justice Tindall said that every person who enters into a learned profession undertakes to bring to it the exercise of a reasonable care and skill. Speaking of a surgeon, he says he does not undertake that he will perform a cure, nor does he undertake to use the highest possible degree of skill, he undertakes to bring a fair, reasonable and competent degree of skill to this case.*" The meaning of due 'care and skill' received the attention of our courts inclusive of the local classicus of *Van Wyk v Lewis* 1924 AD 438 in which the court in Innes CJ at 443 put the position as follows: "*It was pointed out by this court, in Mitchell v Dixon 1914 AD at 525, that 'a medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care.' And in deciding what is reasonable the court will have regard to the general level of skill an diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs. The evidence of qualified surgeons or physicians is of the greatest assistance in estimating that general level.*" And further: Wessels, J.A. in the same judgement on 461 stated: "*We cannot determine in the abstract whether a surgeon has or has not exhibited reasonable skill and care. We must place ourselves as*



The criteria used for measuring the conduct of the medical practitioner is, therefore, that of the reasonable expert, the reasonable practitioner or the reasonable specialist, whichever branch of the medical field is applicable. Although the degree of reasonableness is stated differently by our legal writers, what is generally accepted by them is that when the doctor agrees to administer treatment or perform an operation, he or she does not guarantee to cure the patient (unless the doctor so warrants) but to conduct himself or herself with reasonable knowledge, skill and diligence.<sup>61</sup>

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*nearly as possible in the exact position in which the surgeon found himself when he conducted the particular operation and we must then determine from all the circumstances whether he acted with reasonable care or negligently. Did he act as an average surgeon placed in similar circumstances would have acted, or did he manifestly fall short of the skill, care, and judgement of the average surgeon in similar circumstances? If he falls short he is negligent.*" In a later case of *Castell v De Greef* 1994 (4) SA 408 CPD 416 Ackermann J stated with approval a number of earlier decisions: *"Both in performing surgery and his post-operative treatment, a surgeon is obliged to exercise no more than reasonable diligence, skill and care. In other words, he is not expected to exercise the highest possible degree of professional skill. (Mitchell v Dixon 1914 AD 519 at 525). What is expected of him is the general level of skill and diligence possessed and exercised at the time by members of the branch of the profession to which he belongs. See Van Wyk v Lewis 1924 AD 438 at 444; See also Blyth v Van den Heever 1980 (1) SA 191 (A) at 221A; S v Kramer and Another 1987 (1) SA 887 (W) at 893E - 895C; Pringle v Administrator, Transvaal 1990 (2) SA 379 (W) at 384I - 385E.* The said principle has also been discussed and more clearly defined in a number of reported criminal cases in which medical practitioners found themselves on trial. The elevated degree of care and skill expected of a doctor as an expert was formulated as follows by Steyn J in *R v Van Schoor* 1948 (4) SA 349 (C) 350: *"Coming to the case of a man required to do work of an expert as e.g. a doctor dealing with life or death of his patient, he too must conform to the acts of a reasonable man, but the reasonable man is now viewed in the light of an expert, and even such expert doctor, in the treatment of care and caution than in other circumstances."* The degree of skill expected of a medical practitioner was also defined as follows in *R v Van der Merwe* 1953 (2) PH H 124 (W) in which Roper J remarked: *"Negligence has a somewhat special application in the case of a member of a skilled profession such as a doctor, because a man who practises a profession which requires skill holds himself out as possessing the necessary skill and he undertakes to perform the services required from him with reasonable skill and ability. That is what is expected of him and that is what he undertakes, and therefore he is expected to possess a degree of skill which corresponds to the ordinary level of skill in the profession to which he belongs."* As to what constitutes reasonableness, in the same judgement of *R v Van der Merwe* Roper J remarked: *"In deciding what is reasonable regard must be had to the general level of skill and diligence possessed and exercised by the members of the branch of the profession to which the practitioner belongs. The standard is the reasonable care, skill and diligence which are ordinarily exercised in the profession generally."*

<sup>61</sup> For legal writings see Van Oosten (1996) 82 who defines reasonableness in a medical context as: *"Not the highest possible degree of professional care and skill" or "the standard of the exceptionally able doctor but rather conduct with reasonable knowledge, ability, experience, care, skill and diligence is expected of the ordinary or average doctor endowed with the general level of knowledge, ability, experience, care, skill and diligence possessed and exercised by the profession, bearing in mind that a doctor is a human being and not a machine and that no human being is infallible."* The latter opinion together with the fact that medicine is viewed as a profession filled with inherent risks and dangers, have influenced legal critics in believing all medical mishaps and errors of judgement do not necessarily constitute medical negligence. See Van Oosten (1996) 82. In so far as wrong diagnosis is conceded see Strauss (1991) 306 - 307 the author expresses the following opinion: *"Despite the advances of our century, medicine still is not - and probably never will be - an exact science comparable to mathematics. Much depends on the skill and experience of the individual practitioner."* And further: *"No inference of negligence can be made merely on the basis that the diagnosis was wrong. The courts have time and again pointed out how difficult it is to make a correct diagnosis. The language of the body is limited and the range of possible diseases almost limitless."* Gordon Turner and Price (1953) 109 lays down the following test: *"To establish liability it is not sufficient to prove that the diagnosis was wrong, let alone that other practitioners disagree with the*



The test for the standard of care expected of a medical practitioner is often formulated as: How would a reasonably competent practitioner in that branch of medicine have acted in a similar situation? If a reasonable practitioner would have foreseen the likelihood of harm and would have taken steps to guard against its occurrence but the medical practitioner whose conduct is under investigation failed to, his conduct would fall below the standard of care expected.<sup>62</sup>

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*defendant's opinion. It must be shown that the first opinion was not only wrong but that it was given unskillful, and therefore the doctor was negligent in not exhibiting that degree of skill which is expected of an ordinary medical practitioner or, of course, of a specialist, if he is one.*" And further: "A physician or surgeon possessing the requisite qualifications and applying his skill and judgement with ordinary care and diligence to the diagnosis and treatment of a patient is not liable for an honest mistake or error of judgement in making a diagnosis or prescribing the mode of treatment where there is ground for reasonable doubt as to the practise to be pursued. Where it is clear that the defendant erred in his diagnosis because of a perfunctory or careless examination of the patient, he will be held culpable." See also Van Oosten (1986) *Medicine and Law* 22-24; Dada and McQuoid-Mason (2001) 22: 'That a doctor will not be liable for an error in diagnosis unless it is so palpable as to per se proof of negligence.' See also Gordon Turner and Price (1953) 110. See further Strauss and McQuoid-Mason and Strauss (1983) Par 189 who describe reasonableness as "the general level of skill and diligence possessed and exercised by members of the branch of the profession to which the practitioner belongs." See further Strauss *Doctor, Patient and The Law* (1991) 95 who describes the duty of care of a doctor as "a duty no greater 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 generally not do." See also Claassen and Verschoor (1992) 115 - 116. The authors state that when the physician agrees to administer the necessary treatment or perform an operation, he or she, generally, is not expected to cure the patient (unless the physician guarantees the result). Nevertheless, the physician has a duty 'to treat the patient with such measure of skill and competence as can reasonably be expected from a physician belonging to his branch of the profession.' Where the physician does however guarantee that the patient will be cured and fails to achieve the result, the patient may be able to claim damages for breach of contract. See McQuoid-Mason and Strauss 17 *LAWSA* (1983) Par 189; Claassen and Verschoor (1992) 116; Strauss and Strydom (1967) 106 - 107; See also the discussion on the professional duty to heal or to care Carstens and Pearmain (2007) 642ff. For case law the aspect whether by undertaking a case, a doctor guarantees that the patient will be cured of the disease was first mentioned but not decided upon by Nicholas J in *Buls v Tsatsarolakis* 1976 (2) SA 891 (T) at 893 in which the Honourable Judge remarked: "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 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? It is an interesting question but, because it was not argued and because it is not necessary for the purposes of the present decision to answer it, I shall not discuss it further." 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." In a recent reportable judgement of *Castell v De Greef* 1994 (4) SA 408 CPD 416 Ackermann J also dealt with this aspect when he stated: "It must also be borne in mind that the mere fact that an operation was unsuccessful or was not as successful as it might have been or that the treatment administered did not have the desired effect does not, on its own, necessarily justify the lack of diligence, skill or care on the part of the practitioner. (Compare *Van Wyk v Lewis supra* 462). No surgeon can guard against every eventuality, although readily foreseeable, most, if not all, surgical operations involve to a greater or bigger extension element of risk, and from time to time mishaps do occur, and no doubt will continue to occur in the future, despite the exercise of proper care and skill by the surgeon."

<sup>62</sup> For the legal writings see Dada and McQuoid-Mason (2001) 23; See also McQuoid-Mason and Strauss *LAWSA* (1983) Par 189.

From the above it is clear that a reasonable expert standard has been created and the test of negligence distinguished between the standard of care and skill required of specialists as opposed to general practitioners. If the doctor is a general practitioner, the test is that of the reasonable practitioner. If the doctor is a specialist, the test is that of the reasonable specialist in the branch of the profession to which he or she belongs.<sup>63</sup>

Where a general practitioner engages in an undertaking, either treatment or an operation that requires a certain degree of training, knowledge, experience, skill, competence or diligence, knowing full well that he or she lacks such experience and expertise, the practitioner will be bound to his or her undertaking and judged accordingly.<sup>64</sup>

The degree of skill and care that can be expected is largely a question of evidence and may include factors such as the prevailing, universal, customary or usual practise of the profession, the place where the medical intervention or treatment is performed or given, the facilities available at the hospital where the medical intervention is performed, the financial resources of the hospital authority, the nature of the medical intervention or treatment, the different conditions or emergency situation in which the medical intervention takes place etc.<sup>65</sup>

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<sup>63</sup> For legal writings see Van Oosten Encyclopaedia (1996) 83; See also Claassen and Verschoor (1992) 15. For case law concerning the principle that the medical practitioner's negligence conduct must be measured against the conduct of a reasonable skilled practitioner in his or her field was confirmed without reservation in an Appeal Court decision of *Mitchell v Dixon* 1914 AD 519 at 525 in which Innes ACJ stated that: "A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care, and he is liable for the consequences if he does not." The foretasted principle has also been followed in a host of latter judgments. See in this regard: *Copan v Imply* 1916 CPD P309 at P314; *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) 723 - 724; *Bulls v Tsatsarolakis* 1976 (2) SA 891 (T) 893 - 894; *Byrne v East London Hospital Board* 1926 EDL 128 at 157 - 158; *Dale v Hamilton* 1924 (WLD) 184 at 200; *Lymbery v Jefferies* 1925 (AD) 236 at 245; *Castell v De Greef* 1993 (3) SA 501(C). It has also been decided before by our courts that, what is expected is, however, not the highest possible degree of professional care and skill but rather what can be expected of the ordinary or average doctor applying the general level of knowledge, ability, experience, care, skill and diligence belonging to the branch of the profession to which the practitioner belongs. The position is set out as follows in the *locus classicus* of *Van Wyk v Lewis* 1924 (AD) 438 at 444 which role Innes CJ expressed himself as follows: "It was pointed out by this Court, in *Mitchell v Dixon*, that a medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care."

<sup>64</sup> For the standard of conduct expected of a practitioner in these circumstances see Claassen and Verschoor (1992) 15 who express the opinion that "his performance will then have to comply with the standard of conduct of a reasonable specialist belonging to the same specialty the practitioner professes to be a member of." See also Van Oosten Encyclopaedia (1996) 83; See further Carstens May (1988) *De Rebus*; See further Dada and McQuoid-Mason (2001) 22.

<sup>65</sup> See Van Oosten Encyclopaedia (1996) 54, 84; See also Claassen and Verschoor (1992) 14 -15, 18, 22; See further Strauss and Strydom (1967) 266, 268; See further also Gordon Turner and Price (1953) 110ff with regard to the locality where the practitioner finds himself practicing. Supporting the view expressed in *Van Wyk v Lewis* 1924 AD 438 at 457 namely: "The ordinary medical practitioner should, as it seems to me, exercise the same degree of skill and care, whether he carries on his work in the town or the country, in one place or another. The

A clear distinction is drawn in our case law between the degree of knowledge, experience, care and skill expected of a specialist as opposed to that of a general practitioner. Of a specialist, it is submitted; a greater degree of skill is expected than of a general practitioner. His or her standard of conduct is elevated to the reasonable expert standard. The distinction in expected conduct of a specialist, as opposed to that of a general practitioner, is stated in a number of cases.<sup>66</sup>

What is also of great importance is where the standard of conduct of a specialist is assessed; his conduct is measured against the reasonable specialist in terms of the branch of the profession to which he or she belongs.<sup>67</sup> A greater standard of care and skill is also

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*fact that several incompetent or careless practitioners happen to settle at the same place cannot affect the standard of diligence and skill which local patients have a right to expect."* The authors comment as follows: *"This must surely be correct. What difference can it possibly make to the skill and care required of a practitioner in himself, whether he is attending a patient in Cape Town or in some remote farm on the edge of the Kalahari Desert? The other view seems to arise from a confusion of thought between skill and care and the circumstances in which they must be exercised. A country practitioner may often be obliged to attend a patient in most difficult and trying circumstances; but sometimes a town practitioner is placed by an emergency in an equally unpleasant position."* See also Strauss and Strydom (1967) 268 – 270. *Contra* Carstens "The Locality Rule in cases of medical malpractice" De Rebus 1990 which I submit is the correct view. The writer states: *"While it is true that there is uniformity in the training of medical practitioners in this country today and that the standard of training is in all probability comparable with the best in the world, it cannot be denied that South Africa is a developing country and in many instances a Third World country. Therefore, though a doctor may be suitably qualified, possessing all the subjective qualities, training and capabilities to be a good doctor, should he be placed in a remote country district where there is a lack of medical facilities and infrastructure (the objective reality of the locality) to support the effective practice of First World medicine, this must surely be a factor to be taken into consideration when evaluating his conduct in cases of medical malpractice. Can one really equate the excellence, infrastructure, diagnostic and other equipment of for instance the Johannesburg General Hospital with those of a missionary hospital in a remote country district?"* The author goes on to state: *"The law still requires of a doctor a reasonable degree of skill, which is dependent on the particular circumstances of the case which he has under treatment. It is submitted that the locality rule is nothing but an added 'particular circumstance' that must be given consideration when deciding whether the doctor's conduct was negligent or not. In my opinion the locality where a medical practitioner operates will always be relevant in cases of medical malpractice until such time when it can safely be stated that the medical facilities and equipment in this country are equally available and accessible, irrespective of whether the medical practitioner chooses to practice in the city or in the country."*

<sup>66</sup> For case law see *R v Van der Merwe* 1953 (2) PHH 124 W in which Roper J drew a distinction as follows: *"When a medical practitioner is tried, the test is not what a specialist would or would not have done in the circumstances, because a general practitioner is not expected to have the same degree of knowledge and skill and experience as a specialist has. When a specialist tells you that he would do this, that and the other thing it does not follow that you must expect the general practitioner to act in the same way. But the question is what is the common knowledge in the branch of the profession to which, the accused belongs? What is the common knowledge and accepted practise among the general practitioners? When the specialist tell you what is common knowledge in the profession that is evidence which you are entitled to rely on, because the general practitioner is expected to be possessed of knowledge which is common in the profession."* This dictum was endorsed by Bekker J in *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 at 723 - 724; The distinction in the standard of care expected from a specialist as reasonable expert as opposed to that of the general practitioner is also recognised in *Buls v Tsatsarolakis* 1976 (2) SA 891 (T) at 893 - 894; *S v Mkwetshana* 1965 (2) SA 493 (N) 496; *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (WLD) at 384.

<sup>67</sup> See *Van Wyk v Lewis* 1924 (AD) 438 at P444; *R v Van der Merwe* (1953) (2) PHH 124 (W); *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 at 723 - 724; *Buls v Tsatsarolakis* 1976 (2) SA 891 T at 893 - 894; *S v*

expected of a practitioner and/or nursing staff where more complicated medical procedures are executed.<sup>68</sup>

In certain instances our courts will also depart from the general rule of measuring the conduct of a specialist or medical practitioner in terms of the branch of the profession to which he or she belongs. Where the courts apply the principle *impurities culpa adnumeratur*, a general practitioner would be negligent if he or she undertook work requiring a certain degree of training, knowledge, experience, competence or skill associated with a specialist and which the general practitioner lacks and where the general practitioner knows full well that he or she lacks such qualities.<sup>69</sup>

#### 5.2.6 The Doctor/Hospital's duty to execute the patient's instructions honestly, faithfully and with care

From what was stated earlier, the relationship between the doctor/hospital and patient is essentially a private law matter and is governed by the law of obligations, from which a Doctor/hospital is entrusted with a number of duties some of which have been discussed previously. From the agreement which comes into being between the doctor/hospital and patient a further duty arises, namely, the doctor/hospital will execute the patient's instructions honestly, faithfully and with care.<sup>70</sup>

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*Mkwetshana* (1965) (2) SA 492 (N) at 496.

<sup>68</sup> See *Collins v Administrator, Cape* 1995 (4) SA 73 (C) at 82 wherein Scott J emphasizes: "*The need for particular care and vigilance in the case of the paediatric tracheotomy patient is obvious. But cautions the court: "But a standard of excellence cannot be expected which is beyond the financial resources of the hospital authority."*

<sup>69</sup> In one of the first cases decided in South Africa in which this rule was applied Kotze J in *Coppen v Impey* 1916 CPD 309 stated the position as follows: "*Unskilfulness on his part is equivalent to negligence and renders him liable to a plaintiff, who sustained injury there from, the maxim of law being imperitia culpa adnumeratur (Inst 4 3 7; Van Leeuwen Het Rooms-Hollandsche Recht 4 39 4; Voet Commentarius d Pandectas 9 2 23). The English Law agrees with our own, as may be gathered from what was said by a great master of the common law of England, Tindal CJ in Lampher v Phipos (8 C&P 475), and from numerous other decisions.*" The rule was also applied in the criminal law case of *S v Mkwetshana* 1965 (2) SA 483 (N) 496 in which a young intern at a hospital was charged on a count of culpable homicide in which the accused raised his inexperience as part of his defence. The appeal court in rejecting his defence showed us the position as follows at 497: "*Either the appellant had insufficient knowledge and experience of the drug, in which case it was negligence on his part to administer it; if he knew little, if anything, about it he was subjecting his patient to a considerable risk. For him to have done that in the light of his experience, and particularly his inexperience of the drug and its uses, marks him as being negligent.*" Other cases in which this rule was used where a doctor engaged in an undertaking that required a certain degree of training, knowledge, experience, skill, competence or diligence when in truth he lacked such qualities. He was judged by his undertaking. See *Dale v Hamilton* 1924 WPD 184 at 203; *R v Van der Merwe* 1953 (3) PH H12 4 (W); *Byrne v East London Hospital Board* 1926 ECD 128 at 157 - 158; *R v Van Schoor* 1948 (4) SA 351 - 352; *Buls v Tsatsarolakis* 1976 (2) SA 891 T at 893 - 895.

<sup>70</sup> See Van Oosten Encyclopaedia (1996) 53, 55; See also Claassen and Verschoor (1992) 116; See further Strauss and Strydom (1967) 111 who supports the theory advocated by De Wet and Van Wyk (1992) 308 namely

Because of the doctor's specialised expert knowledge and the highly confidential nature of his services, the doctor is said to find himself in a relationship of particular trust<sup>71</sup> and skill in which the doctor is expected to exercise reasonable care during his or her treatment of the patient.

The trust position, being referred to in foreign jurisdictions as the fiduciary nature of the doctor-patient relationship, which entails that doctors have an obligation to their patients to act with the utmost good faith and loyalty and never allow their personal interests to conflict with their professional duty.<sup>72</sup>

Very little has been written whether a fiduciary relationship exists between a doctor and patient in South Africa. Although a doctor's fiduciary duty exists in the company law sphere,<sup>73</sup> no reason exists in logic why such duty should not be recognised, by our courts,

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generally where a mandate is given in terms of an agreement between two parties, a relationship of trust is created between the mandator and the mandatory which results in the mandatory, when executing the mandate promote the interests of the mandator without boosting his own interests. Carstens and Pearmain (2007) 947ff persuasively argue that at the heart of the relationship between a health professional and the patient is the fiduciary position between them in which trust between the patient and provider is critical for the ultimate wellbeing of the patient. They go on to say that *"if a patient does not trust a healthcare professional, he/she is unlikely to take the latter's advice concerning treatment or to believe a diagnosis."* The Health Professions Council has also published a set of professional guidelines which has an ethical basis and which require that health practitioners *inter alia* honour the trust of their patients as the practitioner is in a position of power over a patient he/she should avoid abusing his or her position. The guidelines are available at <http://www/hpcs.co.za/hpcs/default.aspx>: a copy of the guidelines is attached as an annexure at the back of the book of Carstens and Pearmain (2007).

<sup>71</sup> See Strauss and Strydom (1967) 111; See also Claassen and Verschoor (1992) 116.

<sup>72</sup> See Picard and Robertson (1990) 4 -6; See also Chapman (1984) 81 who quotes from Gisborne: *"An Enquiry into the Duties of Men in the Higher and Middle Classes of Society in Great Britain, Resulting from Their Respective Stations, Professions, and Employment."* (1794) 396 of the original work. In his chapter on physicians, Gisborne discusses rules of professional etiquette, and of gracious doctor-to-doctor conduct, truth-telling in the clinical setting and other matters. Then, setting out his main theme, he stated: *"Diligent and early attention and an honest exertion of his best abilities are the primary duties which the physician owes to his patient. The performance of them is virtually promised, for he knows that it is universally expected when he undertakes the case of the sick man, and consequently, if he neglects to fulfil them, he is guilty of a direct breach of his engagement."* He goes on to say that the physician's concern for the patient's recovery must be uninfluenced by private and personal considerations, and that he must shun "all affectation of mystery." Contra Martin Norton's view expressed in 1980 "Ethics in Medicine and Law: Standards and Conflicts" *Med. Trial Technique Quart.* (1980) Annual: 376. namely: *The moral responsibility to our patient, to society, and to those who, in their despair, seek out aid, not our responsibility to our profession, or to our personal convenience or aggrandizement. This does not imply self-deprivation but rather a return to idealism, to that truly fiduciary relationship which places the client/patient first and foremost in the time-honoured traditions of service, duty, and honour."* More recently Mankesines and Deaken *Tort Law* 4ed (1999) 85, recognizing the fiduciary nature of the doctor-patient relationship states that: *"the doctor in this relationship commands a pre-eminent position due to his superior knowledge, ""As a result of this, the relationship manifests aspects of a fiduciary nature giving rise to a duty of loyalty to the patient."*

<sup>73</sup> See Cilliers and Benade (1982) 327 who recognizes that a director stands in a fiduciary relationship to his company with the result that he has a duty to act in good faith towards his company to exercise his powers as director for the benefit of the company and to avoid a conflict between his own interests and those of the



in the medical law sphere in South Africa.

### 5.2.7 The Hospital's general duty towards the Patient

The non-delegable duty of a hospital exists as an independent legal ground in South African on which hospital liability is founded.<sup>74</sup>

Generally the non-delegable duties are founded on statutes,<sup>75</sup> situations which are

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company. Should the director transgress such a relationship and as a result thereof damages are suffered the director may be legally liable arising from the said relationship. See however the more recent writings of Carstens and Pearmain (2007) 947-948 regarding the fiduciary relationship between the health professional and the patient. See further the professional guidelines issued by the Health Profession's Council published as an annexure at the back of the textbook of Carstens and Pearmain (2007) in which the health service provider is called upon to honour the trust of his/her/its patients and not abuse his/her/its position of power.

<sup>74</sup> See Cronje-Retief (2000) 418.

<sup>75</sup> See Cronje-Retief (2000) 418 who states in South Africa a wide variety of statutes regulate health care, health and the treatment of persons or patients in general. In this regard the author states the hospital generally has a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment which also includes the following duties (1) the hospital must exercise reasonable care to maintain safe physical premises, buildings, grounds and environment for patients, medical staff and guests. (2) The hospital must exercise reasonable care in providing safe, proper and sufficient equipment, stocks, medication and food. The use of defective equipment which causes injury or death, leads to direct hospital liability. In this regard the hospital owes a duty (duties) to patients to provide proper equipment since equipment directly affects patient's lives and their well-being. The provision of defective equipment, and failure to repair it, would also constitute non-compliance with this duty. (3) The hospital must exercise reasonable care in providing a safe and proper system regarding the provision and handling of medication, drugs, prescriptions and doctor's orders for necessary medicines and injections. (4) The hospital has a duty to provide a proper system to effectively control infection and contagious diseases. See also Gordon Turner and Price (1953) 130 - 136; See further Claassen and Verschoor (1992) 150; The other duties according to Cronje-Retief (2000) 419 include *inter alia* to oversee all persons who practice medicine within its walls as to patient care which also included the following duties: (i) The hospital has a duty to exercise reasonable care by overseeing (traditionally supervising) patient care. In this regard the hospital has to persist in ascertaining continually whether all personnel are still competent by providing training and courses, and by following up all necessary information which may indicate the contrary. Hospitals are held liable on account of that which they had known or should have known which affects the competency of personnel/staff and ultimately affects the quality of patient care which is rendered. (ii) The hospital has a duty to exercise reasonable care in the provision of patient care. This includes (1) the hospital may under certain circumstances not refuse to admit a patient, and should not move the patient. (2) Prompt and suitable treatment should be provided after a patient is admitted to a hospital. (3) A hospital could be liable for discharging a patient too soon. (3) Patients should be prevented from falling out of bed especially children and the elderly. (3) The hospital must provide adequate staff. Other duties include: (iii) the hospital should provide proper and safe systems to safeguard all persons, including patients, from patients who have a tendency to commit suicide, or behave abnormally, are violent or do window-leaping, or are criminals. (iv) The hospital has a duty to exercise reasonable care in the provision of specialized patient care. (v) The hospital has a duty to compile and maintain proper medical records. (vi) The hospital must provide reasonably competent specialists and ensure that they are qualified and competent enough to provide such specialized services or expertise. Hospital privileges may only be granted to such competent and qualified medical professionals and privileges should be restricted or refused when there is evidence which indicates the contrary. (vii) The hospital has a duty to provide reasonable emergency care when providing such services. (viii) Hospitals have a duty to employ only qualified, trained and competent non-physician staff such as nurses, X-ray and laboratory technicians and other staff. See also Claassen and Verschoor (1992) 106 - 107; Gordon Turner and Price (1953) 127 - 128; Van der Walt (1979) 72; Van der Walt and Midgely (1997) 139 - 141; Van Dokkum



inherently dangerous; by virtue of the common law, as a result of advertising, reputation or public policy and expectation, and in terms of other *indicta*.

### 5.3 THE PATIENT'S DUTY TOWARDS THE DOCTOR/HOSPITAL

#### 5.3.1 The Patients general duty towards the Doctor/Hospital

##### 5.3.1.1 Legal Writings

It has often been said that where a doctor/hospital enters into an agreement with the patient in terms of which the doctor undertakes to treat the patient, the patient must also perform his part of the agreement. Writers generally are adamant, the patient's duty besides paying the fees <sup>76</sup> to the doctor/hospital amount to nothing more than making

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(1996) De Rebus 253. In so far as healthcare is concerned, it is especially the *National Health Act* 61 of 2003 which play a pivotal role in prescribing the duties bestowed on hospitals to exercise their obligations in treating patients with care and the necessary skill. Note particularly sections 2 and 3 dealing with the objects and responsibilities for health. In both sections the protection, promotion, improvement and maintenance of health is emphasized. See further the general duties of healthcare providers in the public and private sectors discussed by Carstens and Pearmain (2007) 379ff; 413ff. For South African case law endorsing the hospital's duties see *Lower Umfolozi District War Memorial Hospital v Lowe* 1937 NPd 31. *In casu*, the nurse had placed a warm water bottle in the bed of a patient who was recovering from the effects of an anaesthetic, after undergoing a liver operation. As a result his right leg was severely burnt, for which he claimed damages. The court recognized the duty of the hospital to make sound selection of staff in that the only duty that was repeatedly acknowledged being owed to patients by a hospital was: "*the duty of the hospital to select duly qualified nurses or medical staff, by using due care and skill. This duty has been acknowledged and upheld by most legal systems and is the most common in terms of usage and historically, the first (direct) duty ever to be created in Hillyer.*" See also *Lymbery v Jefferies* 1925 AD 236, the radiologist Mr Ensor, was unqualified but had a long practical experience. He nevertheless severely burnt the plaintiff. The action was, however, instituted against Dr Jefferies who had sent the Plaintiff to Mr Ensor. The court found that he was in charge of the radiology department at Pretoria Hospital. It is submitted that the action should have been instituted against the hospital (1) on the ground of direct liability for having selected an unqualified radiologist, or, (2) on the ground of vicarious liability for the negligence of the hospital's employee. In a similar case of *Byrne v East London Hospital Board* 1926 EDL 128 the court was also asked to pronounce on the hospital's negligence in securing a radiologist to assist with the operation. In this case, the radiologist was qualified but lacked experience. The radiologist, Dr Hollis, had burnt the doctor, who operated (plaintiff), as well as the patient whom he had operated on and a nurse. The operation was performed on the patient's hand, whilst the radiologist screened it under an X-ray plant which was operated by him. At the time of his appointment (as radiologist) Dr Hollis discontinued an X-ray course after attending only two lectures on X-ray work. He had indicated on his application form that he was attending such a course but did not reveal discontinuance of the course to the defendants. Dr Hollis did, in giving evidence, profess to be ignorant and inexperienced when employed and at the date of the operation. He had only been assisted by the previous radiologist for two months.

Graham JP relied on the Hillyer case and its application in the Hartl case and found that the board was not negligent in the appointment of Dr Hollis. The board had every reason to suppose that they had procured in the person of Dr Hollis the services of a competent and zealous radiologist. On account of the authorities he had referred to, he did not find the hospital liable. This conclusion was drawn in spite of the fact that he had previously found that '*circumstances surrounding the operation tend to show either incompetency or negligence on his part.*'

<sup>76</sup> See Van Oosten Encyclopaedia (1996) 71 - The author states that the patient or the person responsible for the maintenance of such patient shall be responsible for payment of the doctor/hospital's account after the delivery of a detailed account provided of course the account accurately reflects the services rendered. The fees payable shall also be in accordance with the prescribed tariffs as provided for by the *Medical, Dental and Supplementary Health Service Professions Act* 6 of 1974 unless otherwise agreed to between the parties involved. In that event where

himself or herself available for treatment.<sup>77</sup>

### 5.3.1.2 Case Law

The only case I came across in South African law which dealt with the doctor's remedy for breach of contract, arising from the patient's failure to present himself for treatment, is that of *Myers v Abrahamson*.<sup>78</sup> In this case, the doctor claimed payment of the balance of his fees in respect of a verbal agreement of service entered into between the doctor and patient. The patient filed a counterclaim, claiming the return of certain disbursements already paid to the doctor.

### 5.4 The Patient's Right to Information

The recognition and acceptance of the patient autonomy model by our legal writers,<sup>79</sup> the

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the doctor wishes to exceed the tariffs usually charged for such services, the doctor is obliged to inform the patient before he/she commences the rendering of the professional services. See also Section 53(6) of the *Medical, Dental and Supplementary Health Service Professions Act*. See also Strauss and Strydom 117 who take the view that a patient who remains in default for non payment is in breach of the contractual agreement and may be sued for the capital amount as well as any interests which may accrue as a result of the responsible patient or person's failure to make timeous payment. See also Claassen and Verschoor (1992) 117 who express the opinion that in certain circumstances the patient may withhold payment for example "*where a practitioner commits breach of contract the patient is exempted from his obligation to remunerate the physician for his services.*" See also Gordon, Turner and Price (1953) 74; See further Dada and McQuoid-Mason (2001) 6.

<sup>77</sup> See Strauss and Strydom (1967) 115 – 119; Strauss and Strydom (1967) 116; See McQuoid-Mason and Strauss *LAWSA* (1983) 145 with regard to the remedy of the doctor in the circumstances in that: "*The doctor may sue the patient for breach of contract in the form of mora creditoris.*" See also Strauss and Strydom (1967) 116; Claassen and Verschoor (1992) 117; See further McQuoid-Mason and Strauss (1983) 145 who suggest the doctor's claim for damages against the defaulting patient may be calculated by taking the fee which the doctor would have earned for attending to the patient, less any sum he actually earned. This is a view also supported by Gordon, Turner and Price (1953) 74. See also Dada and McQuoid-Mason (2001) 6. Besides the academic writings, the *National Health Act* 61 of 2003 also lay down duties in respect of users which they must obey which duties include:

"(a) adhere to the rules of health establishment when receiving treatment or using health services health establishment;

(b) subject to section 14 provide the healthcare provider with accurate information pertaining to his or her health status and co-operate with healthcare providers when using health services;

(c) treat healthcare providers and health workers with dignity and respect; and (d) sign a discharge certificate or release of liability if he or she refuses to accept recommended treatment."

<sup>78</sup> 1952 (2) SA 121 (C) at 127 - The court held: "*The measure of damages accorded wrongfully dismissed employee is the actual loss suffered by him represented by the sum due to him for the unexpired period of the contract less any sum he earned or could reasonably have earned during such latter period in similar employment.*"

<sup>79</sup> See Van Oosten (1996) 68-69 who classifies the rationale of the patient's right to information as: "*Ensuring the patient's right to self-determination and freedom of choice and to encourage rational decision-making by enabling the patient to weigh and balance the benefits and disadvantages of the proposed intervention in order to come to an enlightened choice either to undergo or to refuse it.*" See also Van Oosten (1989) 58 449-450; Strauss and Strydom (1967) 212-213; Claassen and Verschoor (1992) 62-63; See further Dada and McQuoid-Mason (2001); Carstens and Pearmain (2007) 313ff-875ff.

courts<sup>80</sup> and national legislation,<sup>81</sup> entrenches a greater right to the patient to be supplied with sufficient information in order for him or her to make informed decisions.

The need to supply the patient with sufficient information arises particularly from the technical nature of most forms of medical treatment and surgical operations which are at times accompanied by medical risks.<sup>82</sup>

There are however factors which may influence the patient's right to information. Such factors which have been identified include, *inter alia*, the patient's desire for information,<sup>83</sup> the patient's temperament and health,<sup>84</sup> the patient expressly or impliedly waives his or her right to information.<sup>85</sup>

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<sup>80</sup> For the consequences that may arise where the medical practitioner fails/refuses and/or neglects to recognize the patient's right to information see *Dube v Administrator Transvaal* 1963(4) SA 264 (T) in which the court held that a failure to inform the patient clearly and unambiguously after setting the patient's arm in plaster, that if anything abnormal is noticed, the patient is to return to the hospital immediately, constitutes negligence by the hospital. See *Sombabis v Administrator of the Orange Free State* 1989(0) (unreported, discussed in Strauss (1991) 4 26) wherein which it was highlighted a failure to advise a diabetes patient with a foot injury not to use his foot but to rest it resulted in the doctor incurring liability for negligence. See also *Ramsaroop v Moodley* (1991) (N) Unreported a failure to inform the patient to have a sperm count before resuming intercourse with his wife without contraception after having undergone a vasectomy. See also *Friedman v Glicksman* (1996) (1) SA 11 in a failure to correctly advise the patient of a greater than normal risk or danger of giving birth to a handicapped or disabled child in order to enable her to make an informed choice whether to proceed with or terminate her pregnancy may render the doctor liable for damages. See further *Castell v De Greef* (1994) 408 at 520-421; *Broude v McIntosh* 1998 (3) SA 60 (SCA); *Jackson v Carpenter-Kling* 1998 (T) Unreported; *Oldwage v Louwrens* (2004) 1 ALL SA 532 (C); *McDonald v Wroe* Unreported (CPD); *Louwrens v Oldwage* 2006 (2) SA 161 (SCA).

<sup>81</sup> The *National Health Act* 61 of 2003 in Chapter 2 of the Act deals specifically with the rights and duties of the users. Section 6 in particular deals with the user's right to full knowledge of the procedures, treatment and consequences so that he/she can make an informed choice.

<sup>82</sup> See Strauss (1984) 8-9; See also Claassen and Verschoor (1992) 62-63; See further McQuoid-Mason and Strauss *LAWSA* Volume 17 (1983) 149. For case law see *Castell v De Greef* (1994) 408 at 418.

<sup>83</sup> See Van Oosten (1996) 7. The author takes the view that when dealing with an inquisitive patient, the doctor is obliged to give more detail than usually expected from the doctor.

<sup>84</sup> See Strauss (1984) 8. The author advocates restrictions on the supply of information in certain instances including where the patient's state of mind is such that full awareness of the severity of his condition or of the drastic nature of the treatment indicated, would be therapeutically detrimental to the patient. See also *Castell v De Greef* (1994) (4) 408 at 427.

<sup>85</sup> See Van Oosten (1996) 71. The author recognizes that in some instance medical paternalism inhibits the flow of information to the patient in that it is a recognised fact in practice that, despite the patient's right to self-determination, he has the outmost faith and confidence in the doctor, so much so, that the patient relies fully on the doctor to make decisions on his or her behalf. The patient then prefers to have little or any information about the medical procedure and waives his right thereto. See Claassen and Verschoor (1992) 36 69 who state that in instances where the patient himself or herself indicates that he or she does not wish to be informed of the nature of the proposed treatment, the risks involved or the probable consequences, the medical practitioner is exempted

## 5.5 The Doctor's Duty of Confidentiality

Because of the nature of the doctor-patient relationship the patient has a fundamental need for privacy. Should this need be respected the patient is encouraged to freely disclose his/her symptoms and condition to the doctor. A patient will, however, be unwilling to do so unless the patient has some form of guarantee that the doctor will not share such confidential information with others. Moreover, health is also described, by the writers Carstens and Pearmain,<sup>86</sup> as one of the most sensitive areas for many people when it concerns issues of privacy. It follows that where the health information of a patient is not protected and a lack of privacy occurs, it could harm a patient in many ways.<sup>87</sup> On the other hand, there may be a need to protect innocent members of society from threatening health risks due to irresponsible patient behaviour, the need to contain diseases that are highly contagious and potentially have a significant impact on public health. In those circumstances, it may be necessary, in public interests, to publish information which otherwise would have been confidential. In these instances the patient's right to privacy is disregarded in order to protect, for example, the lives of health professionals and the public at large.<sup>88</sup>

Besides the patient's rights to privacy and confidentiality being protected by the common law, such rights are also protected by legislation.<sup>89</sup>

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from his or her duty to disclose.

<sup>86</sup> (2007) 943ff.

<sup>87</sup> Carstens and Pearmain (2007) 943 expresses the opinion that a lack of privacy of the patient's health information may adversely impact upon larger prospects and employment status, adversely impact upon their own state of mental health, lead to victimization and stigmatization in the broader environment and cause problems in spousal or parent-child relationships.

<sup>88</sup> Carstens and Pearmain (2007) 1000ff.

<sup>89</sup> Commencing with the Constitution, section 14 of the Constitution although it does not definitively define the right to privacy to a patient it does give some scope; See Carstens and Pearmain (2007) 953ff. See also the *Promotion of Access to Information Act 2 of 2000* which prohibits the disclosure of personal information in the absence of prior consent. See sections 34 and 67 of the Act. It also deals specifically with health records sections 30 and 61 of the Act. The *National Health Act 61 of 2003* also contains extensive provisions that support and uphold the patient's right to privacy. With regard to confidentiality this Act stipulates that all information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment is confidential. It goes on to provide that no person may disclose any such information unless:

- the user consents to that disclosure in writing;
- a court order or any law requires that disclosure; or
- non-disclosure, of the information represents a serious threat to public health.

See section 14(2). The Health Provisions Council in its published guidelines referred to supra deals specifically with an accused right to privacy and confidentiality when requiring that practitioners *inter alia*: "..... Recognize the right of patients to expect that they will not pass on any personal and confidential information they acquire in the course of their professional duties, unless they agree to disclosure, or unless there is a good and

Universally then, certain protective measures have been put in place which encourage the free flow of information.<sup>90</sup>

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*overriding reason for doing so. (Examples of such reasons may be any probable and serious harm to an identifiable third party, a public health emergency, or any overriding and ethically justified legal requirements.) Do not breach confidentiality without sound reason and without the knowledge of the patient .....*"

<sup>90</sup> For legal writings see McQuoid-Mason and Strauss *LAWSA* (1983) Par 200 who state 'if this were not so patients would be unwilling to make certain disclosures to the physicians and this could inhibit their treatment.' See also Van Oosten *Encyclopaedia* (1996) 90 who expresses a similar fear in that unless patients can freely divulge certain confidential information to their doctors, without fear that 'such facts become public policy', infected members of the public will not 'come forward to be counselled and treated.' See also Dada and McQuoid-Mason (2001) 17; Carstens and Pearmain (2007) 943ff. The patient's right to privacy, is a well recognized principle in other countries and internationally gathered from the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights (ICOPR); the World Medical Association's International Code of Medical Ethics which requires that: "A physician shall preserve absolute confidentiality on all he knows about his patient even after the patient had died." The Declaration of Helsinki of the World Medical Association also provides that in medical research, doctors must protect human life, health, privacy and dignity. For case law see *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (A), the facts of which can briefly be stated as follows: A doctor told another doctor and a dentist while playing golf that one of the patients had HIV/AIDS. The patient had asked his doctor not to disclose the facts to anyone. The second doctor had once done a locum for the first doctor and the dentist had treated the patient. Neither the second doctor nor the dentist was treating the patient at the time. The court in looking at the purpose and function of the doctor's duty of confidentiality stated at 850 as follows: "According to the rules of the SA Medical and Dental Council (the Council) it amounts to unprofessional conduct to reveal any information which ought not to be divulged regarding the ailments of a patient with the express consent of the patient. (Rule 16, is to be found in, Strauss *Doctor, Patient and The Law 3rd ed* (1991), at 454). The reason for the rule is twofold. On the one hand it protects privacy of the patient. On the other it performs a public interest function. This was recognised in *X v Y and Others* (1988) 2 ALL ER 648 (QB) at 653a-b where Rose J said: 'In the long run, preservation of confidentiality is the only way of assuring public health; otherwise doctors will be discredited as a source of education for future individual patients "will not come forward if doctors are going to squeal on them." Consequently, confidentiality is vital to secure public as well as private health, for unless those infected come forward they cannot be counselled and self-treatment does not provide the best care.' A similar view was expressed by the Supreme Court of New Jersey in *Hague v Williams* (1962) 181 Atlantic Reporter 2d 345 at 349: 'A patient should be entitled freely to disclose his symptoms and condition to his doctor in order to receive proper treatment without fear that those facts become public property. Only then can the purpose of the relationship be fulfilled.' In *Financial Mail (Pty) Ltd v Sage Holdings Ltd* 1993 (2) SA 451 (A) the court put it quite strongly when observing that there is a public interest in preserving confidentiality in regard to private affairs and in discouraging the leaking of private and confidential information, unlawfully obtained, to the media and others. It was also held in the *Christian Lawyers Association v Minister of Health (Reproductive Health Alliance)* as *amicus curiae* 2005 (1) SA 509 (T) matter that informed consent is not given to the common law. It forms the basis of the doctrine of *violen fit injuries* that justifies conduct that would otherwise have constituted a delict or crime if it took place without the victim's informed consent. Similarly, in a more recent judgement involving the *Minister of Health, Manto Tsabalala-Msimang*, and the court with strong reference to Section 14 of the Constitution recognizes that "human beings have a right to have a sphere of intimacy and autonomy which should be protected from invasion." See *Manto Mbazana Edmie Tshabalala-Msimang and the Medi Clinic Ltd v Mondli Makyana, Jocelyn Maker, Megan Power and Johnnic Publications* unreported case no 18656/07 (WLD) 3. In this case the court relies heavily on the *Natural Health Act* 61 of 2003 in finding that the possession of the private and confidential medical records by the Sunday Times and by its employees was unlawful. See Page 17, and further, on the effect of sections 14, 15, 16, 17 of the Act, the court emphasizes that "..... where a person acquires knowledge of private facts through a wrongful act of intrusion, any disclosure of such facts by such person or by any person in principle, constitutes an infringement of the right to privacy."

The protective measures put in place are that of medical ethics<sup>91</sup> and medical law<sup>92</sup> which dictate that the patient has a right to privacy and that the doctor is under a duty of confidentiality.<sup>93</sup> Where a medical practitioner discloses information regarding a patient's private affairs and he or she has no defence to such disclosure, the medical practitioner may incur civil or criminal liability as his or her

<sup>91</sup> See McQuoid-Mason and Strauss *LAWSA* (1983) Par 200; See also Van Oosten Encyclopaedia (1996) 90; See further Dada and McQuoid-Mason (2001) 17; Carstens and Pearmain (2007) 947ff on the influence of ethics. See further The Health Professions Council Rules regarding the patient's right to privacy and the doctor's duty of confidentiality and in particular Rule 16 which prohibits divulging any information regarding a patient which ought not be divulged, except with the express consent of the patient or, in the case of a minor, 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 his estate.

<sup>92</sup> Medical Law bestows a legal duty of medical confidentiality on the doctor not to divulge certain information regarding the patient. See McQuoid-Mason and Strauss *LAWSA* (1983) Par 200; See also Van Oosten Encyclopaedia (1996) 90; See further Dada and McQuoid-Mason (2001) 17. In a number of cases our courts have also imputed a legal duty on doctors in respect of patient's private affairs, for example disclosure that the patient was suffering from a sexually transmitted disease. See *Parkes v Parkes* 1916 CPD 702; Disclosure of the Patient's Mental State of Health. See *Ex Parte James* 1954 (3) SA 270 (SR); Disclosure of patient's fitness to be awarded custody of children in a divorce trial. See *Botha v Botha* 1972 2 SA 599 (N); Disclosing of physical abuse of detainees. See *Davis v Additional Magistrate Johannesburg* 1989 (4) SA 299 (W); Disclosure that the patient was suffering from Aids. See *McGeary v Kruger and Joubert* (1991) (W) Unreported. See also *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (A).

<sup>93</sup> The foundation of its existence has been described by some writers as that founded in contract. See Van der Poel (1998) 21. Other writers have founded the existence of this duty in the Hippocratic Oath which required the medical practitioner to preserve the confidence of patients. See Dada and McQuoid-Mason 2001 17. *Contra* Van Oosten Encyclopaedia (1996) 91 who state that "*the legal duty of medical confidentiality usually arises from common law but may also be imposed by statute,*" i.e. Section 33 of *The Human Tissue Act* which provides: "33. Prohibition of publication of certain facts - (1) No person shall publish to any other person any fact whereby the identity of -

- (a) a deceased person whose body or any specific tissue thereof has been donated;
- (b) the donor of the body of a deceased person or any specific tissue thereof;
- (c) a living person from whose body any tissue, blood or gamete has been removed or withdrawn for any purpose referred to in section 19; or
- (d) the person who has given his consent to the removal of any tissue, blood or gamete from the body of a living person for such a purpose, may possibly be established, unless consent thereto was granted in writing by the deceased person concerned prior to his death, or after his death by a person referred to in section 2(2) (a)."

*Contra* Dada and McQuoid-Mason (2001) 17 who express the view that 'a breach of confidence by a doctor or health professional may be an infringement of the patient's common law and constitutional rights.'

In terms of Section 14 of the *Constitution Act* 108 of 1996 "Privacy 14 Everyone has the right to privacy, which includes the right not to have -

- (a) their person or home searched;
- (b) their property searched;
- (c) their possessions seized; or
- (d) The privacy of their communications infringed."

See the comprehensive work of Carstens and Pearmain (2007) 943ff in which the writers highlight, especially the influence of the *National Health Act* 61 of 2003 which deals with the patient's right to privacy and confidentiality.



act constitutes *iniuria*.<sup>94</sup>

### 5.5.1 Defences to Breach of Confidentiality

The patient's right to privacy and the doctor's duty of confidentiality are, however, not absolute rights but rather relative, in that, the law recognises certain actions of disclosure as justifications which may operate as defences to the doctor's invasion of the patient's private sphere or disclosures of the patient's private affairs.<sup>95</sup>

The defences include consent,<sup>96</sup> privilege,<sup>97</sup> court order, litigation between the parties or

<sup>94</sup> For a discussion on the legal position as per legal writings see Van Dokkum "Should Doctor-Patient Communications be privileged?" Nov (1996) *De Rebus* 748. For case law supporting the view that such conduct constitute *iniuria* see the cases of *McGeary v Kruger and Joubert* (1991) (N) Unreported and *Jansen van Vuuren v Kruger and Another NNO* 1993 (4) SA 842 (A). It has also been held that conduct is defamatory. See *Ex Parte Rautenbach* (1938) SR 152-153. It has also been held where the conduct results in patrimonial loss such may even be a breach of contract. See *Jansen van Vuuren v Kruger and another NNO* (1993) (5) SA 842 (A) at 848-849. See further *Parkes v Parkes* 1966 (CPD) 702 and *Botha v Botha* 1972 (2) SA 999 (N).

<sup>95</sup> For legal writings see Van Oosten Encyclopaedia (1996) 92; See also Strauss (1991) 106; See further Dada and McQuoid-Mason (2001) 20; See further Van Dokkum (1996) 748; See also McQuoid-Mason and Strauss *LAWSA* (1983) Volume 17 2000. For a very comprehensive discussion on the justification on acts of disclosure in certain circumstances see Carstens and Pearmain (2007) 982ff. For case law our courts have also recognised that the patient's right to privacy and the doctor's duty of confidentiality are not absolute rights. In this regard the court in *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (A) at 850 stated: "*The duty of a physician to respect the confidentiality of his patient merely ethical but is also a legal duty recognised by the common law. See Melius de Villiers - The Law of Injuries at 108. As far as present day law is concerned, the legal nature of the duty is accepted as axiomatic. See for example, Sasfin (Pty) Ltd v Beukes 1989 (1) SA 1 (A) at 31F - 33C; Neethling Persoonlikheidsreg 3rd ed at 236; McQuoid-Mason - The Law of Privacy in South Africa at 193-4. However, the right of the patient and the duty of the doctor are not absolute but relative. See S v Bailey 1981 (4) SA 187 (N) at 189 F-G; Sasfin case supra; Sage Holdings Ltd v Financial Mail (Pty) Ltd 1991 (2) SA 117 (W) at 129H-131F; Financial Mail case supra at 462F-463B. One is, as always, weighing up conflicting interests and, as Melius de Villiers (loc cit n 29) indicated, a doctor may be justified in disclosing his knowledge `where his obligations to society could be of greater weight than his obligations to the individual' because the action of injury is one which pro publica utilitate exercetur'. To determine whether a prima facie invasion of the right of privacy is justified, it appears that, in general, the principles formulated in the context of a defence of justification in the law of defamation ought to apply. See McQuoid-Mason (op cit at 218); Neethling (op cit at 247). It is therefore not surprising that the defences pleaded by the first defendant in justification have the foundation of defamation defences, namely privilege, truth and public benefit and in general terms, the boni mores*" In the more recent case of *Tshabalala-Msimang and Medic Clinic Ltd v Modli Makhanya and Others* Unreported case no 18656.07 (WLD) the court with reference to the *Financial Mail (Pty) Ltd v Sage Holdings Ltd* case emphasized especially, "the overriding considerations of public interest which would permit publication." See page 26-27. In this regard the court stresses the fact that the public has the right to be informed of current news and events concerning the lives of public persons such as politicians and public officials. The court also emphasizes the purpose of the press, namely, "..... to advance the public interest by publishing facts and opinions without which a democratic electorate cannot make responsible judgements."

<sup>96</sup> See Van Oosten Encyclopaedia (1996) 92 who advocates that "*consent in this regard may take the form of a contract between the patient and a third party in terms of which the doctor is under a duty to disclose the patient's private affairs to such third party*". An example used by the author is where a contract between employer and employee exists that the latter may be examined by and reported on by the former's doctor. See also Strauss (1991) 107-108; McQueen-Mason and Strauss *LAWSA* (1983) Par 2001; *Contra* Carstens and Pearmain (2007) 982ff who regards consent as a unilateral act which may be provoked at any time.

disciplinary proceedings,<sup>98</sup> statutory authority or statutory duty,<sup>99</sup> emergency situations, public interest or *boni mores*.<sup>100</sup>

<sup>97</sup> See Van Oosten Encyclopaedia (1996) 92 who stated that this type of defence is justified based upon '*the legal, social or moral right or duty to communicate and receive such information.*' See also McQuoid-Mason and Strauss LAWSA (1983) Par 200 who used the example namely a disclosure to a patient's spouse that the patient is suffering from a venereal disease. It is submitted that the same applies to a situation where the spouse is diagnosed as HIV positive. Carstens and Pearmain (2007) 984 with reference to therapeutic privilege justifies the recognition of this defence as having a significant role to play in certain circumstances. The writers use an example of a minor who has been sexually abused by the parents or other family members in whose custody they find themselves. It is ironic the person who may be responsible for providing consent may be the transgressor here it may be in the minor's interests that the healthcare provider invoke therapeutic privilege and not communicate the condition or medical evidence to the person who is suspected of having transgressed. For case law see the obiter dictum comments of Watermeyer CJ in *SA Medical and Dental Council v McLoughlan* 1948 (2) SA 355 at 366 when he stated: "*It may sometimes be advisable for a medical man to keep secrets from his patient the form of treatment which he is giving him.*" See also the case of *VRM v The Health Professions Council of South Africa* (2003) Jol.119 44 (T).

<sup>98</sup> See Van Oosten Encyclopaedia (1996) 92 who state that although ethically the doctor is under a duty to protest to such breach of confidentiality, nevertheless once an order is made compelling the doctor to make such disclosure he/she is obliged to give such evidence. See also Strauss (1991) 112 with regard to this defence. The author opine that "*a doctor who is either a defendant or plaintiff in a civil matter or an accused in a criminal matter or implicated in disciplinary proceedings may invoke this defence where such evidence would be relevant.*" See also Van Oosten Encyclopaedia (1996) 93; McQuoid-Mason and Strauss LAWSA (1983) Par 200. See further the comments of Carstens and Pearmain (2007) 998ff when the authors state that where the law compels disclosure or there is an obligation to disclose in the course of legal processes such as litigation or disciplinary proceedings this can be raised as a defence in a claim for invasion of privacy. For relevant case law see *Parkes v Parkes* 1916 CPD 702; *Botha v Botha* 1972 (2) SA 559 (N); *Davis v Additional Magistrate Johannesburg* 1989 (4) SA 303 (W); *S v Forres* 1970 (2) SA 597 (C).

<sup>99</sup> Carstens and Pearmain (2007) 997ff very aptly describe the recognition of this defence as "*one cannot be punished by the law for obeying the law. If legislation requires the disclosure of certain confidential information and the disclosure is made consistently with the relevant legal provision then a claim for an invasion of privacy cannot succeed.*" The confidentiality of health information as was seen earlier is recognized by the South African legislation. In this regard section 14(2) of the National Health Act 61 of 2003 stipulates that a person may not disclose any information unless:

- " (a) the user consents to the disclosure in writing;
- (b) a court order or any law requires that disclosure; or
- (c) non-disclosure of the information represents a serious threat to public health".

Other legislation includes section 90 of the *National Health Act* which empowers the Minister of Health to make regulations concerning identifiable medical conditions. Section 33 of the *Health Act* 63 of 1977 gives some indication of the kind of regulations that the Minister may make in the public interest with regard to common diseases. For other legislation see Section 79 of the *Criminal Procedure Act* 51 of 1977, Section 13 of the *Mental Health Act* 17 of 2002, Section 42(1) and (5) of the *Child Care Act* 74 of 1983 provides for in certain instances for the disclosure of the patient's private affairs for example the medical examination or medical treatment to persons reasonably suspected to be suffering from communicable diseases or a psychiatric evaluation of an accused in a criminal prosecution in order to determine if he or she is fit to stand trial or patients suffering from dangerous mental illness or child abuse cases. See further McQuoid-Mason and Strauss LAWSA (1983) Par 200; Van Oosten *Encyclopaedia* (1996) 93.

<sup>100</sup> See Van Oosten Encyclopaedia (1996) 93 - 94 who expresses the view that '*in emergency situations alternatives where public interest or the boni mores so dictate, an invasion of the patient's private sphere or a disclosure of the patient's private affairs may be justified.*' for example, where information is given relating to a spouse suffering from a sexually transmissible disease. See also the comprehensive writings of Carstens and Pearmain (2007) 1000ff. The authors state that the right to privacy would be subject to the duty to protect the health and lives of

## 5.6 Summary and Conclusions

It is evident from the chapter that, arising from the contractual relationship between the doctor/hospital and patient are numerous duties and obligations bestowed on both the doctor/hospital and the patient. The question of whether the doctor or hospital is obliged to treat the patient was explored, albeit very briefly. The answer to this lies in the fact that a clear distinction has to be drawn between public hospitals, with doctors in their employ and private doctors who practise for their own account and private hospitals. In the situation public hospitals and doctors in their employ find themselves, they are obliged to treat patients as they are state run and they are bound by their constitutional obligations. In the situation involving private doctors and private hospitals, save for emergency situations, they are not obliged to treat patients. They can, therefore, generally accept or refuse patients as they wish. This chapter also included a brief discussion on the doctor/patient's duty to obtain the patient's consent before commencing treating the patient or performing surgery. It also included a brief discussion on what information the doctor/hospital is obliged to make available to the patient before the patient is said to make an informed decision resulting in informed consent. It is clear that sufficient information has to be given regarding the proposed treatment and/or surgery, especially, the risks attached the inherent dangers and any alternatives that may be suggested.

Other clear and distinct duties and obligations which emerged from the discussions in this chapter include the duty to treat the patient, which in turn focused on the duration of the treatment and the nature and extent of the treatment. It is clear from the discussion in this chapter that unless the patient makes treatment impossible, the doctor/hospital is obliged to see the treatment through, once he/she/it has started their treatment of the patient, until the patient is cured or the practitioner makes other suitable arrangements. It is also clear from the discussion in this chapter that the nature and extent of the treatment to be administered is that of the exercise of a duty of due care and skill. Of all the duties arising from the contractual relationship, this is a core value inherent in the doctor-patient

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members of the public where they are in clear and present danger for example the outbreak of deadly haeborlogic fever such as Ebola, or to control cholera. The same applies it is submitted to a situation where an HIV/Aids patient refuses, after being advised to do so, to disclose his condition then in such event the doctor is obliged to do so. Public interests or the boni mores as a justification may occur in a custody battle where the interests of a child in divorce proceedings are at stake. See *Botha v Botha* 1972 (2) SA 559 (N); It may also be used as a defence where the interests of other health care workers are threatened. See *McGeary v Kruger and Joubert* (1991) (W) Unreported; *Jansen van Vuuren v Kruger* 1993 (4) SA 342 at 850; See also the important case of *C v Minister of Correctional Services* 1996 (4) SA 292 (T). Information to others regarding a patient's interests may also be justifiable for example disclosure in cases of mental illness associated with suicidal tendencies or terminal illness in a dying patient. See in this regard also Strauss (1991) 22; See further Gordon, Turner and Price (1953) 52-53.

relationship. For that reason, even in instances where it is not expressly agreed to, the duty to exercise due care and skill arises in the form of an implied term. The nature of the standard of care to be exercised is not the highest possible degree of skill, but rather a reasonable and competent degree of skill expected of the branch of the profession to which the doctor or specialist belongs. Therefore, there is also a clear distinction between the standard expected of the doctor, as opposed to the specialist. Furthermore, the doctor or hospital is not expected to produce miracles and does not, save where they guarantee results, warrant that the patient will be cured.

A further duty highlighted during the discussion in this chapter is that the doctor or hospital is to carry out the patient's instructions honestly, faithfully and with care. The rationale behind this is said to arise from the specialist knowledge which the doctor or hospital staff has. This in turn creates a relationship of trust between the doctor/hospital and the patient. This is referred to in other jurisdictions as the fiduciary nature of the doctor/hospital-patient relationship, in which the former is expected to act with the utmost good faith and loyalty, in which the personal interest of the doctor or hospital shall not conflict with their professional duty. It will be argued in a later chapter that, although not part of our jurisprudence, it ought to become part. It will also be argued that this is a factor which must be considered when assessing the validity of exclusionary clauses in hospital contracts.

Besides the fore stated duties, there is a further duty which is imputed to the doctor/hospital arising from their contractual relationship with the patient. The duty of confidentiality commences as soon as the patient consults the doctor or the hospital for treatment. The nature of the duty of confidentiality prohibits the doctor or hospital staff from revealing information which ought not to be divulged regarding the ailments of the patient unless there is a ground for justification, for example, consents, privilege, court order or public interest.

The patient, on the other hand, also incurs obligations arising from the patient's relationship with the doctor or hospital. The obligations are, however, limited or restricted to, paying the fees charged for medical services and to make himself/herself available for treatment.

The discussions in this chapter, as well as the preceding Chapters 3 and 4, covered the nature of the contractual relationship between the doctor/hospital and the patient. The discussions included the formation of the contractual relationship and the accompanying requirements, as well as all the formalities that need to be complied with. The discussions also included a detailed discussion of the obligations that flow from such a contractual

relationship and the duties that flow from the relationship. One of the primary duties that flow from such a relationship is that of the doctor/hospital's duty of care which arises *ex contractu*. This duty is inherent to the doctor/hospital-patient relationship and can be expressly agreed to. In the absence of such an express agreement it also arises by implication, flowing from the inherent duty of care.

The following chapter will consider the inherent duty of care which the doctor/hospital has towards his/her patient outside a contractual sphere. What will be considered will be the nature of the duty. The standard of care of the doctor, as opposed to a specialist, will also be considered, as well as influencing factors, *inter alia*, the locality rule will be looked at. This chapter is a build-up to Chapter 7, in which the limitation or exclusion of the duty of care of doctors/hospitals will be discussed.