



Chapter 6
The Doctor/hospital's general duty of care towards the patient

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6.1 Introduction

It was stated before that besides the duty of care owed to their patients in contract,¹ doctors/hospitals/other health care providers also owe their patients a duty of care in delict.

² The duty of care arises quite independently of any contract, or, it may exist side by side with the contractual obligation. ³ Whatever the position, it is submitted that there is really one duty, generating alternative or concurrent remedies or cause of action. ⁴

In order to acquire a greater understanding of the doctor's duty of care and to what extent codes of ethical conduct influence the standard of behaviour of the practitioner's, it is necessary to look briefly at the nature of the doctor's duty of care, the doctor's standard of

¹ See generally our legal writers in: Gordon Turner and Price (1953) 75 FF; Strauss and Strydom (1967) 106 FF; Strauss (1991) 3ff; McQuoid-Mason and Strauss (1983) Volume 17 *LAWSA* 144 - 145; Van Oosten Encyclopaedia (1996) 54 - 55; Claassen and Verschoor (1992) 115 - 116; Dada and McQuoid-Mason (2001) 5; Carstens and Pearmain (2007) 413ff. See generally the following case law: *Van Wyk v Lewis* (1924) AD 448, 469-470. *Allott v Paterson and Jackson* (1936) 224; *Kovalsky v Krige* (1910) 204 TR pp. 822, 823; *Coppen v Impey* (1916) CPD pp. 309, 314; *Buls v Tsatsarolakis* 1976(2) SA pp. 891(T), 893; *Applicant v Administrator Transvaal* 1993(4) SA pp. 733(W) 738; *Collins v Administrator Cape* (1998) (4) SA 73, 81-82.

² See generally Gordon Turner and Price (1953) 108. The authors opine that the doctor's liability for delict is not dependent upon the existence of a contract between the parties at all; See also Strauss and Strydom (1967) 266; McQuoid-Mason and Strauss (1983) *LAWSA* Volume 17 151; Claassen and Verschoor (1992) 118; Van Oosten (1996) 57; Dada and McQuoid-Mason (2001) 22; Strauss (1991) 36 - 37, 331. See further Strauss: "Duty of Care of Doctor towards Patient may arise Independent of Contract." SA Practise Mann. Vol. 9 155 2 (1988). Carstens and Pearmain (2007) 489ff; for case law see: *Correia v Berwind* 1986(4) SA 60 66ff; *Van Wyk v Lewis* (1924) AD pp. 443-444; 455-456; *Collins v Administrator Cape* (1995) (4) 73, 81; *Buls v Tsatsarolakis* 1976(2) SA 891(T).

³ See Claassen and Verschoor (1992) 115 - 124. The authors takes the view that in contract, the duty of care arises from the agreement between the patient and physician which involves "the physician who undertakes to execute the patient's instructions honestly, faithfully and with care, which standard of care as a specialized expert is to exercise reasonable care and skill during his treatment of the patient." In delict, someone who enters a profession or vocation which, requires special knowledge or skill for example a physician "The physician is burdened with a duty of care to exercise reasonable skill and care during the treatment of the patient." See also Neethling, Potgieter and Visser (1989) 4 - 5. The authors opine: "There is no fundamental difference between a delict and a breach of contract, and the injured party can choose to act on the one or the other."

⁴ See Claassen and Verschoor (1992) 118; the authors use the example of a surgeon who for example performs an operation in an improper manner. The surgeon according to the authors "would firstly be guilty of breach of contract because he does not perform properly in terms of the agreement. Secondly, the commission of an unlawful act is also present because the surgeon injures the patient's rights of personality regarding the integrity of his person, despite the contract." See also Neethling et al (1989) 5. For case law see *Van Wyk v Lewis* (1924) AD 438; *Correia v Berwind* 1986 (4) SA 60 63 66. With regard to concurrence of remedies see Claassen and Verschoor (1992) 125 who opine that: "One of the same acts may lead to different claims for which different remedies are available." The authors continue that where the remedies available to the patient are delictual and contractual in nature "the Plaintiff may choose between the one and the other or sue in the alternatives." See also Van der Merwe and Olivier (1985) 462 463 and 467; See further Neethling et al (1989) 213-214.

care and the elevated standard of care of the medical specialist.

A greater understanding of the doctor's duty of care will also assist in determining whether a doctor/hospital/other health care provider may lawfully limit or exclude his/hers or its duty of care? An answer to the aforementioned is of particular importance for the focal point of this thesis.

6.2 THE NATURE OF THE DOCTOR/HOSPITAL'S DUTY OF CARE

6.2.1 SOUTH AFRICA

6.2.1.1 Legal Writings

As a starting point the question needs to be begged, where does this duty come from? The origin of the doctor's duty of care, as was previously stated, is founded in normative ethics, various ethical codes, regulations and the Hippocratic Oath itself, which dates back almost to the days when medical practice first emerged. It has its first traces, although rather rudimentary, during the ancient period ⁵ and continued during the Greek period, when, with the rise of intellectual levels, ethics and rights actions were documented, which included the Hippocratic Oath. The doctor's duty of care continued to be recognised during the Roman Era, when, for the first time, Ulpianus, in his writings, recognised that the doctor's duty of care arises *ex contractu* as well as under the *Lex Aquilia*. ⁶ This continued to be the position in the Post Roman Era and similarly represents the position today.

In terms of the ethics of the profession, ⁷ it appears therefore, that a physician is under a general duty to act and to treat a patient. Although such a duty is not expressly imposed by the Oath of Hippocrates, nevertheless, the Geneva Declaration of 1968 imposes such a duty, which physicians have to swear to, amongst others: "*I shall treat human life with the greatest respect; even when I am deceived, I shall not exercise my knowledge of medicine*

⁵ See Cronje-Retief (2000) 25; Sanbar et al (1995) 6; Rhodes (1985) 11 - 12; See also Porter (1999) 54-61; See further the comprehensive work of Carstens and Pearmain (2007) 607ff on the origin and development of medical negligence.

⁶ See Amundsen (1973) 17 - 25; Carstens and Pearmain (2007) 611ff.

⁷ See Picard et al (1996) 1; See also Holdsworth (1923) 385; See further Jones (1998) 18; Mason and McCall-Smith (1991) 14-17; Ficarra (1995) 117; Skegg (1988) 8; *Contra* Midgley "Ethical and Legal Duties" (1990) *De Rebus* 525. The writer points out the role of codes of ethics as follows: "*Codes of Ethical conduct record standards of behaviour against which practitioners conduct can be reassured.*" The writer continues: "*Their purpose is to ensure client's welfare and they also create duties in respect of the profession and the public at large.*" More recently Carstens and Pearmain (2007) 263 opine that medical ethical values include professional competence, compassion, justice, confidentiality, human rights, truthfulness which serve the interests of the patients.

in conflict with the laws of humanity."⁸

Whatever the moral or ethical consequences may have been for a physician who refused to give medical help to a sick or injured person, it was generally accepted that he would not incur criminal or delictual liability merely by virtue of such refusal.⁹

The traditional approach that a person could not be held liable by virtue of a mere omission, it is submitted, no longer holds sway in South African law. Today it is accepted that a mere omission can, in fact, lead to delictual as well as criminal liability where the circumstances are such that the person concerned could personally be expected to intervene.¹⁰

6.2.1.2 Case Law

⁸ Geneva Declaration 1968.

⁹ See Voet in *Commentaries ad Pandectas* 9.2.3 as translated by Gane. *The Selective Voet being the Commentary on the Pandectas* (1955 - 1958). The eminent Roman-jurist by the turn of the 17th century wrote, although "it would suit the duty of the good man to come to help the imperilled fortunes of his neighbour, if he can do it without hurt to himself." Nevertheless, wrote the writer, "A doctor who refuses to attend a patient cannot be held liable under the Aquilian law." See also Strauss - Doctor, Patient and The Law (1991) 23 who states the traditional view of our law was that "failure on the part of someone to act 'positively' to ward off danger from another (or to protect the latter's interests otherwise) generally could not lead to any liability on the part of the former." It is for that reason that Strauss op cit 24 states that: "In our law the doctor's right of refusal was traditionally 'mere omission'." The author however places a caveat in that "in certain instances liability for an omission can be incurred for example where the defendant has by a positive act created a potentially dangerous situation and refrains from taking steps to avoid the danger; where the defendant has assumed control over a dangerous object and then neglects to exercise proper care over it; where the defendant is under a statutory duty to act and neglects to do so; where the defendant has by contract assumed certain duties and fails to carry them out." See also Van Oosten (1996) 59 - 61; See further Strauss and Strydom (1967) 175; Gordon Turner and Price (1953) 123; McQuoid-Mason and Strauss (1983) 190; Claassen and Verschoor (1992) 38 - 39 117.

¹⁰ See Strauss (1991) 24 - 25. The author holds the view that there are instances when the courts may part with the traditional view in that: "A court may now well hold a doctor liable for harm suffered by an injured or ailing person, where the doctor was aware of his condition and unreasonably refused or failed to attend." According to Strauss op cit 25, in establishing whether or not a failure to act was unreasonable, the court will be guided by factors such as: "(1) The doctor's actual knowledge of the patient's condition; (2) the seriousness of the patient's condition; (3) the professional ability of the doctor to do what is asked of him; (4) the physical state of the doctor himself (he is a human being and if he is completely exhausted, superhuman efforts will not be demanded of him); (5) the availability of other doctors, or even of nurses and paramedics; (6) the interests of other patients; (7) whether attending to the patient would expose the doctor to danger; (8) whether the patient is desirous or not to be treated; (9) professional ethical considerations." As to the latter factor Strauss emphasizes that professional ethical considerations "cannot be underrated" in that the rules of the South African Medical and Dental Council (now the South African Professional Health Services Council) as with other international codes of ethics have repeatedly underlined "the duty of the doctor to respect and protect human life." This protection is today also guaranteed by the Constitution of the Republic of South Africa Act 108 of 1996. See Section 11. For a duty to act imposed by statute, see Regulation 13 under Section 33(1)(j) of the Health Act; Section 47(1)(b) of the Health Act; (Now replaced by the Health Care Act 61 of 2003); Section 42(1) and (5) of the Child Care Act. (Now replaced by the Children's Act 38 of 2005). For a discussion on the liability for omissions in general, see also Boberg "Liability for Omissions" (1982) 11 BML 194.

The well-established traditional expression that a mere or pure omission cannot found liability is well embedded in the South African case law.¹¹

It was particularly since the case of *Silva's Fishing Corp (Pty) Ltd v Maweza*¹² that the courts adopted a less dogmatic approach in applying the traditional rule. The courts commenced to adopt the standpoint that prior conduct may create a legal duty to guard against any foreseeable harm and to take reasonable steps in so doing. In this case the defendant was the owner of a fishing fleet. A boat put out to sea under the command of an employee of the defendant. The crew on board was engaged by the employee and the profits of the catch were to be divided on a certain basis among the defendant, his employee and the crew. The engine of the vessel failed and it drifted for nine days until wrecked in a storm. The husband of the plaintiff was drowned. The widow claimed damages from the owner of the boat.

The majority of the judges decided that the defendant's provision of a boat and his concurrence in the voyage which was also to this financial benefit, constituted potentially noxious conduct on the part of the defendant. The court held that what arose from this conduct was a duty not only to provide a reasonably safe boat, but also adequate alternative means of propulsion or suitable means of rescuing the crew of a drifting boat or both. In the minority judgement, the control of the boat, which the defendant exercised through his employees on board, was accepted as the source of a duty to take reasonable steps to rescue the endangered crew. The defendant's failure to act was clearly a breach of that duty.

In a subsequent case of *Administrator Cape v Preston*¹³ the appellant had, in a cattle district, constructed a cutting in a national road which was designed to accommodate an overhead bridge for transport. After completion of the cutting, the bridge was built by the railways administration. A herd of cattle, driven along the national road, stampeded as a result of the noise of a train crossing the bridge and two fell from the top of the cutting onto the road. The plaintiff claimed damage from the appellant. The court decided that the

¹¹ See *Halliwell v Johannesburg Municipality* 1912 (AD) 654 at 670-5; *Cape Town Municipality v Clohessy* 1922 (AD) 41; *De Villiers v Johannesburg Municipality* 1926 (AD) 401 at 405; *SAR&H v Estate Saunders* 1931 (AD) 276 281; *Minister of Forestry v Qwathlamba (Pty) Ltd* 1973 (3) SA (A) 80-81; *Silva Fishing Corp (Pty) Ltd v Maweza* 1957 (2) SA 264 (A); *Peri Urban Area Health Board v Munarin* 1965 (3) SA 367 at 373.

¹² 1957 (2) SA 265 (A).

¹³ 1961 (3) SA 562 (A).

construction of the cutting alone, leaving out of account the noise of trains crossing the bridge, did not constitute a potential danger to cattle. The cutting became a potential hazard when the bridge was subsequently built. Although the bridge was not built by the appellant, the court nevertheless concluded that the conditions created by the appellant's previous conduct in constructing the cutting constituted the potential danger to cattle traversing the road. The construction of the cutting, as part of a project which included a bridge over the cutting, was therefore accepted as an act from which a duty of care arose.

The doctrine of the duty of care was further applied in the case of *Minister of Forestry v Quathlamba (Pty) Ltd*,¹⁴ the court decided that once an owner of landed property in a rural area, which is under his control, becomes aware that a fire has broken out on or has spread to his property, and he ought reasonably to have foreseen the possibility of harm to others if no precautionary measures were taken, there rests upon him a duty to take reasonable steps to control or extinguish the fire. The court held the scope of the duty, and whether it has been breached depends on the particular circumstances of the case. Some of the considerations which must, *inter alia*, be taken into account are: the point of time when the landowner became aware of the fire, the stage when he should reasonably have foreseen the likelihood of the fire spreading beyond the confines of his property and the resources available to him to combat the fire.

Although the courts recognised the concept that a duty to act, it so recognised the duty to act, only in certain specific instances. However, in *Minister van Polisie v Ewels*¹⁵ the appellate division clearly rejected the concept that a duty to act only arises in certain specific instances. The court expressed the view that our law has developed to a stage where an omission is regarded as wrongful when the circumstances of the case are such that, not only does the omission incite moral indignation, but, the legal convictions of the community also require a legal sanction. The inquiry into the existence of a duty to act does not involve the *bonus paterfamilias* test, but simply the question whether, with reference to all the circumstances of the case, a duty arises. In this case, the court had no hesitation in pronouncing that such a duty rested on a policeman who refrained from protecting a person who was being assaulted. The court, in arriving at this conclusion, took into account the statutory duties of a policeman, the fact that the assault took place on the premises of the police station, the particular relationship of protection between a policeman and an ordinary person, and the fact that the defendant could, without difficulty, have intervened on behalf

¹⁴ 1973 (3) SA 69 (A).

¹⁵ 1975 (3) SA 590 (A).

of the assaulted plaintiff.

Liability for omissions in a medical context received the attention of our courts since the case of *Kovalsky v Krige*¹⁶ in which the plaintiff alleged *inter alia* that the doctor was negligent in not remaining with the patient until the situation was safe to leave. A similar allegation was relied upon in *Webb v Isaac*.¹⁷ In *Mitchell v Dixon*¹⁸ the alleged omission was based on the breaking of a needle of a syringe used during exploration of the chest cavity for suspected pneumonia-thorax.

In the leading case of *Van Wyk v Lewis*¹⁹ which involved a swab which was sewn up in a patient, the very omission to detect the swab before sewing up the patient formed the basis of the claim for liability. The omission to ensure that a specimen, taken out during surgery reached a research institute formed the basis of alleged liability in the case of *Hewat v Rendell*.²⁰

Allegations of medical liability arising from an omission by the medical practitioner or hospitals through the action of their staff members continued to receive the attention of the courts without the courts pronouncing thereon.²¹

It was however only in 1981, when the courts, following the Ewels judgement, pronounced that an omission in medical law cases gives rise to liability. In *Magware v Minister of Health NO*²² Smith J based his judgement in favour of the patients largely on the Ewels ruling. The Judge held there was a moral and professional duty on the part of the casualty staff to act reasonably towards the patient. Taking into consideration the special relationship which

¹⁶ (1910) 20 CTR 822.

¹⁷ (1915) (EDL) 273.

¹⁸ (1914) AD 519 at 530.

¹⁹ (1924) (AD) 438.

²⁰ 1925 (TPD) 679.

²¹ See *Prowse v Kaplan* 1933 EDL 257; *Allott v Paterson & Jackson* 1936 SR 281; *R v Van Schoor* 1948 (4) SA 349 (C) 352; *R v Van der Merwe* 1953(2) PH H 124(W); *Dube v Administrator Transvaal* 1966 (4) SA 260 (T); *S v Mkwetshana* 1965(2) SA 493(N), 497; *St Augustine Hospital (Pty) Ltd v Le Breton* 1975(2) SA 530(D); *Buls v Tsatsarolakis* 1976 (2) SA (T) 895; *Richter v Estate Hammann* 1976(3) SA 226(C) at 230-231; *Blyth v Van den Heever* 1980(1) SA 191(A).

²² 1981 (4) SA 472.

existed between the staff of the hospital and the patient, the Judge concluded: "*on a consideration of the facts and what could be expected of the casualty medical staff as compared with the consequences of inaction and having regard to the conceptions prevailing in this country, there was a legal duty to act reasonably.*"²³

The principle enunciated has subsequently been followed in a number of judgements.²⁴

6.2.1.3 Legal Opinion

- (1) Besides recognizing the duty of care owed to their patients by medical practitioners/hospital/other healthcare providers in contract, our legal writers and the courts alike, likewise, recognize their duty of care towards their patients even in the absence of a contractual agreement.²⁵
- (2) Though the duty of care arises quite independently of any contract it may however, exist side by side with the contractual obligation.²⁶
- (3) The origin of the doctor/hospital/other healthcare provider-patient relationship is founded in normative ethics, ethical codes and the Hippocratic Oath.²⁷

²³ *Magware v Minister of Health NO 1981 (4) SA 477.*

²⁴ See in this regard the cases of *Correia v Berwind* 1986 (4) 60; *Pearce v Fine* 1986(D) (unreported, discussed in Strauss (1991) 273 ff.); *Soumbabis v Administrator of the Orange Free State* 1989(O) (unreported, discussed in Strauss (1991) 262-263); *Pringle v Administrator Transvaal* 1990 (2) SA 379 (W); *Castell v De Greef* (1994) (4) SA 448; *Collins v Administrator Cape* 1995 (4) SA 73 CPD; *S v Kramer* (1987) (1) SA 887(W). For the liability that arises from the non-performance of a contractual duty to act see: *Edouard v Administrator Natal* 1989 (2) 368 (A); *Administrator Natal v Edouard* 1998 (3) SA 551 (AD); *Friedman v Glicksman* 1996 (1) SA 1134 (WLD); *Clark v Hurst NO* 1992 (4) SA 636 (D).

²⁵ Gordon, Turner and Price *Medical Jurisprudence* (1953) 108, Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 266, McQuoid-Mason and Strauss *LAWSA Volume 17* (1983) 151, Claassen and Verschoor *Medical Negligence* (1992) 118, Van Oosten *Encyclopaedia* (1996) 57; Dada and McQuoid-Mason *Introduction to Medico-Legal Aspects* (2001) 22; Strauss *Doctor, Patient and The Law* (1991) 36-37; Strauss "Duty of Care of Doctor towards Patient may arise independent of Contract" *SA Practise Man*. Vol 9 155.2 (1988). See further Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 413ff-489ff. For case law see *Correia v Berwind* 1986 (4) SA 60 (Z) 66; *Van Wyk v Lewis* 1924 (AD) 438 at 443-444; 455-456; *Collins v Administrator Cape* 1995 (4) SA 73 (C) 81; *Buls v Tsatsarolakis* 1976 (2) SA 891 (T).

²⁶ Claassen and Verschoor *Medical Negligence* (1992) 115ff; See also Neethling, Potgieter and Visser *Deliktereg* (1989) 4-5. The writers opine that there is no fundamental difference between a delict and breach of contract and the party who feels aggrieved can make an election. Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 406ff.

²⁷ Picard *Legal Liability of Doctors and Hospitals in Canada* (1996) 7, Holdsworth *History of English Law* 1923 (385), Amundsen :The Liability of the Physicians in Roman Law" *International Symposium on Society, Medicine and Law Edited by Karplus* (1973) 17-25; Jones *Medical Negligence* (1998) 18; Mason and McCall-Smith *Law and Medical Ethics* (1991) 14-17; Ficarra "Ethics in Legal Medicine" A Chapter dedicated in Sanbar et al *Legal Medicine* (1995) 117; Skegg *Law Ethics and Medicine* (1988) 8; Midgley "Ethical and Legal Duties" *De Rebus August* (1990) 525 all writers put a premium to the roll normative ethics and ethical cases play in setting standards of behaviour against which medical practitioner's conduct are reassured which help towards ensuring the patient's welfare. It

- (4) Although it was generally accepted in South Africa that a mere omission by a medical practitioner would not result in the criminal or delictual liability merely by virtue of such refusal. Today this no longer holds sway in South African Law, as today, unlike yesteryear, it is accepted that a mere omission can lead to delictual as well as criminal liability where the circumstances are such that the medical practitioner is expected to intervene.²⁸

6.2.2 ENGLAND

6.2.2.1 Introduction

Before the nature of the doctor's duty to take care is looked at in more detail, it is important to look briefly at the origin of the doctor's duty of care and its development.

Historically, in English Law, the doctor's duty of care was derived from his status and common calling.²⁹ The profession of surgeons, like the profession of Apothecary, Barber

also imposes a general duty on the medical practitioner to act and to treat a patient. Although the Hippocratic Oath is silent on the general duties of the doctor on when to act, The Declaration of Geneva (1968) however, does impose a general duty especially where human life is threatened. See also the comprehensive work of Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 60ff.

²⁸ This was the common law position. See *Commentaries ad Pandectas* 9.2.3 as translated by Gane which became the traditional view in South Africa. cf. Strauss *Doctor, Patient and the Law* (1991) 23, Van Oosten *Encyclopaedia* (1996) 59-61, Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 175, Gordon, Turner and Price *Medical Jurisprudence* (1953) 123; McQuoid-Mason and Strauss *LAWSA* (1983) Par 190, Claassen and Verschoor *Medical Negligence* (1992) 38-39, 117. See further Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 325ff, 506ff. For case law see the *dicta* of *Haliwell v Johannesburg Municipality* 1912 (AD) 654 at 670-5; *Cape Town Municipality v Clohessy* 1922 (AD) 41; *De Villiers v Johannesburg Municipality* 1926 (AD) 401 at 405; *SAR & H v Estate Saunders* 1931 (AD) 276 281; *Minister of Forestry v Qwathlanba (Pty) Ltd* 1973 (3) SA (A) 80-81; *Silva Fishing Corp (Pty) Ltd v Maweza* 1957 (2) SA 264 (A); *Peri Urban Area Health Board v Munarin* 1965 (3) SA 367 at 373; *Administrator Cape v Preston* 1951 (3) SA 562 (A) in which the South African courts made it clear that a mere omission cannot find liability. *Contra* however, the landmark decision of *Minister van Polisie v Ewels* 1975 (3) SA 590 (A) when the Appellate Division (as it was known then) rejected the concept that a duty to act only arises in certain specific instances. The court consequently held that a mere omission is regarded as wrongful when the circumstances of the case are such that not only does the omission incite moral indignation but the legal convictions of the community also require a legal sanction. For case law in a medical context in which our courts have held that a mere omission by a doctor or hospital staff to do something expected of them see *Kovasky v Krige* (1910) 20 CTR 822; *Webb v Isaac* (1915) (EDL) 273; *Mitchell v Dixon* (1914) AD 519; *Van Wyk v Lewis* (1924) AD 43; *Hewat v Rendell* (1925) TPD 679, *Magware v Minister of Health NO* 1981 (4) SA 472; *Correia v Berwind* 1986 (4) 60 ZHC; *Pearce v Fine* 1986 (D) (unreported, discussed in Strauss (1991) 273ff); *Soumbabis v Administrator of the Orange Free State*; 1989 (O); (unreported, discussed in Strauss (1991) 262-263; *Pringle v Administrator Transvaal* 1990 (2) SA 379 (W); *Castell v De Greef* (1994) (4) SA 408; *Collins v Administrator Cape* 1995 (4) SA 73 CPD; *S v Kramer* (1987) (1) SA 887(W). See *Sedma v Executive Member Gauteng* 2002 (1) SA 776 (T); *Van der Walt v De Beer* 2005 (5) SA 151 (C); *Louwrens v Oldwage* 2006 (2) SA 161 (SCA); *McDonald v Wroe* Unreported (2006) CPD case number 7975/03. For the liability that arises from the non performance of a contractual duty to act see *Edouard v Administrator Natal* 1989 (2) 368 (1); *Administrator Natal v Edouard* 1998 (3) SA 551 (AD); *Friedman v Glicksman* 1996 (1) SA 1134 (WLD); *Clark v Hurst NO* 1992 (4) SA 636 (D).

²⁹ See Holdsworth (1923) 385 - 386. The author sees this as one of the first attempts to place legal constraints and

and Smith, was a 'common calling', the exercise of which imposed on its practitioners a duty to use proper care and skill.³⁰ At first the exercise of the calling was not dependent on any contractual relationship between the surgeon and his patient.³¹

For that reason the liability of the medical man was said to be delictual in its origin, and the exercise of the calling was seen as a matter of public policy, in respect of which, ethics played a major role.³²

In modern law the pendulum has swung in that the duty of care is no longer attributable to the "medical man's" status as such, liability today arises from a breach of contract. The duty of care also forms part of the general liability for the tort of negligence.³³

The same principle applies in relation to hospitals and other medical institutions.³⁴ The

expectations upon those who practiced medicine as a protecting measure in favour of those who received treatment in that "once the medical man" engaged in this 'common calling' he was subjected to "a local rule which developed in that a duty was placed upon the 'medical man' to use proper care and skill." See also Fitzherbert (1534) 94 D. See further Kennedy and Grubb (1998) 285 - 286; See further Teff (1995) 159-160, 173-180; See further Picard and Robertson (1996) 1 - 3.

³⁰ See Fitzherbert (1534) 94 D. See also Wright (1993) 6.

³¹ See Holdsworth (1923) 428-432; See also Wright (1993) 6.

³² See Holdsworth (1903) 386-448; See also Wright (1993) 6.

³³ The authors hold the view that from the doctor-patient relationship arises an "implied contractual duty to act at all times in the best interests of the patient." Following the dictums of Lord Templeton in *Sidaway v Governors of Bethlem Royal Hospital* (1985) A.C. 871, 904B; Jackson and Powell (1997) 592 Footnote 11 endorses the principle namely 'the relationship between the doctor and patient is contractual in origin' in which the doctor "obedient to the high standards set by the medical profession impliedly contracts to act at all times in the best interests of the patient." See also Lewis *Medical Negligence* (1988) 123. The author supports the view that "the physician's duty to take all due care of the patient arises from the relationship of doctor and patient." See further Wright (1993) 7 who describes the relationship between doctor and patient as a 'special relationship'. See further Jones *Medical Negligence* (1996) 30. The author takes the view that "such is the relationship between the doctor and patient" that it "clearly satisfies any test based upon foresee ability of harm, proximity of the relationship between plaintiff and defendant" that "it be just and reasonable to impose a duty of care".

³⁴ See Jones (1996) 30. The writer states that the usual starting point for any discussion of the duty of care in the tort of negligence is the decision of *Donoghue v Stevenson* (1932) A.C. 562 and the famous dictum of Lord Atkin at 580 in which he stated: "You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question." Commenting on the above dictum Jones (1996) 30 identifies the special relationship between the doctor and patient as satisfying the "test based upon foresee ability of harm and proximity which arises from such relationship." See also Jones (1996) 21; See further Jackson and Powell (1997) 13 who supports the theoretical basis for the duty of care in English Law as enunciated by Lord Atkin, in *Donoghue v Stevenson* (1932) AC 562 in that the phrase "injure your neighbour" means nothing else than "to cause some kind of physical or

delictual remedy of *assumpsit* evolved, in which a patient, who sustained an injury by reason of a lack of skill or care by the medical man, could claim damages from the medical man.³⁵

In time concepts of contract became more advanced, with the result, the delictual origin of the liability became somewhat obscured and the duty of care of the medical man arose from the contractual relations between the medical man and his patient.³⁶

6.2.2.2 Legal Writings

There is broad consensus amongst English writers that the doctor/hospital's duty of care arises in tort,³⁷ or out of contract³⁸ or in certain circumstances in tort and simultaneously

psychological harm to the plaintiff." See further Dugdale and Stanton *Professional Negligence* (1989) 90; See further Scott *The General Practitioner and the Law of Negligence* (1995) 7. The author relying on the case of *Donoghue v Stevenson* (1932) AC 562 views the patient as the doctor's legal neighbour in the following light: "If it can be shown that the doctor should realize that a patient might be affected by the treatment then it establishes automatically the neighbour principle." The author continues: "Any treatment, or lack of it, will obviously affect the patient." For that reason the author comments further: "The effect of this is that there is normally no difficulty for a patient who is suing his doctor to demonstrate the first element in his action; that a duty of care did exist." For a discussion of the origin of the duty of care and the nature and scope of such a duty in general terms see the English writings of Harpwood *Principles of Tort Law* (1997) 1; Winfield and Jolowitz on *Tort* (1994) 3 69-70; Street on *Torts* (1993) 17; Charzworth-Percy on *Negligence* (1977) 12; Hepple and Matthews *Tort: Cases and Materials* (1985) 40. See Wright (1993) 11-12. The author holds the view that: "The hospital which receives a patient into its care undertakes towards the patient certain obligations, notwithstanding that its services may be rendered gratuitously or pursuant to an arrangement to which the patient is not a party, as is the case of National Health Service hospitals; indeed the duty owed to a non-paying patient will normally be the same as that owed to a paying patient."

³⁵ See Wright (1993) 6; the author states that "in such cases the consideration for the medical man assuming a duty of care and skill was said to lie in the fact that the patient has submitted himself to the other's care." See also Kennedy and Grubb (1998) 294 who express the view that "the basis for this duty to take care is an 'undertaking' of care of the person as a patient." This follows the view expressed by Nathan *Medical Negligence* (1957) 8 as far back as 1957 when he summed up the undertaking of care implied by the law as: "The medical man's duty of care arises..... quite independently of any contract with his patient. It is based simply upon the fact that the medical man undertakes the care and treatment of the patient." Later Nathan continues: "It is clear that the duty of care which is imposed upon the medical man arises quite independently of contract. It is a duty in tort which is based upon the relationship between the medical man and his patient, owing its existence to the fact that the medical man has assumed responsibility for the care, treatment or examination of the patient, as the case may be." Commenting on the above Kennedy and Grubb (1994) 68, the authors associate themselves with the views expressed above and perceive this to "reflect the position of English Law, as far as it goes, as regards the hospital doctor." See further Kennedy and Grubb (1998) 294 who commenting on the views expressed by Nathan advocates that the language of "undertaking" and "assumption of responsibility" reflects "the modern approach of the courts when imposing positive duties of care, particularly upon professionals."

³⁶ See Holdsworth (1923) Vol. (iii) 448-450; See also Wright (1993) 6; See further Jackson and Powell (1997) 592

³⁷ See Wright (1993) 10. The writer opines that a duty in tort "is based upon the relationship between the medical man and his patient, owing its existence to the fact that the medical man has assumed responsibility for the cure, treatment or examination of the patient, as the case may be." See also Nathan (1957) 8 - 10 discussed in the introduction; See also Kennedy and Grubb (1994) 64 67 - 69 who states that in England this occurs predominantly where an individual becomes a patient of a general practitioner "through mechanism created under the National

out of contract.³⁹ It has also been stated before by the English legal writers that

Health Service Regulations." In that instance the duty of care of the general practitioner arises "after there had been a request for services and the general practitioner has become aware of the need for medical services." A further instance arises where the patient attends a hospital as an in-patient or out-patient. Where the doctor or hospital "has undertaken the care and treatment of the patient" the duty of care arises. See Taylor *Medical Malpractice* (1980) 28 who also takes the view that "the general practitioner owes a duty of care to patients on his National Health Service list" as well as "emergency cases". Likewise the hospital or hospital doctor owes a duty to the patients in the wards as well as an accident and emergency department. See further Kennedy and Grubb (1998) 286. The writers take the view that "it is generally accepted that within the National Health Services today there is no contractual relationship between a doctor and patient nor is there a contractual relationship between the patient and the hospital." Therefore a general practitioner's duty of care towards his or her patients is derived from the regulations contained in the terms of service contained in Schedule 2 of the National Health Service Act 1992" provided of course "there is a direct or indirect request for 'care' from the patient" and "the general practitioner assumes responsibility of the patient" or the "obligation under the Regulations is a continuing one." See further McHale and Fox (1997) 148 – 149; Jackson and Powell (1997)10ff.

³⁸ See Wright (1993) 10. The writer advocates that in general terms, the doctor's duty of care towards his or her patient arises from "the implied term of the contract." See also Kennedy and Grubb (1998) who recognize the implied terms in contract in that doctors are expected "to exercise reasonable care and skill when diagnosing, advising and treating patients" and in the case of hospitals, "to provide for example adequate staff and facilities." The terms implied in the contract in respect of services or goods provided to patients are founded in the relationship between doctor (and hospital) and patient. According to Kennedy and Grubb (1998) 292 the terms are founded in the Supply of Goods and Services Act of 1982. The writers continue that "as many obligations, are statutory, they cannot be excluded." See also Jones (1996) 20 25 27-28; See further Kennedy and Grubb (1994) 70-71; See further Martin Law relating to Medical Practise (1979) 138; See further Jackson and Powell (1997) 591-592 who view the implied contractual duty "to act at all times in the best interest of the patient." See further Dugdale et al (1984) 4-5. For a discussion on the express terms of an agreement, between doctor/ hospital and patient, see Kennedy and Grubb (1998) 288. The writers take the view that the terms expressly agreed to between the doctor/hospital and patient are not restrictive in nature nevertheless they are however "subjected to the constraints of public policy." See also Jones (1996) 24 - 25 who relying on the Unfair Contract Terms Act 32(1) of 1977, holds the view that: "A person cannot, however, by a contractual term or by notice exclude or restrict liability for death or personal injury resulting from negligence. Unfair Contract Terms Act 1977, s2 (1). Any attempt to exclude or restrict liability for other forms of loss or damage resulting from negligence is subject to a test of reasonableness." See further Kennedy and Grubb (1994) 70. The authors place limitations to what the parties may purport to agree through express terms. In that regard the author's state: "They cannot, for example, agree to do that which would be regarded as contrary to public policy, for example, selling an organ (see infra) or to waive those obligations implied by the law See further Dugdale et al (1989) 5 445. Although the writers recognize that certain terms agreed to may provide that liability for negligence is excluded or united in some respect the effect thereof "may be considered unethical" especially "to offer professional services whilst at the same time limiting liability." Contra Wright (1993) 15 who expresses the view that: "It is conceivable, for example, though perhaps scarcely probable, that in individual medical man might seek by his contract with the patient to limit or exclude his liability for negligence. A more likely possibility is that an institution such as a private nursing home might make a similar attempt. There can be no doubt that a properly drafted provision in the contract could, if sufficiently brought to the patient's notice, effectively limit or exclude such liability."

³⁹ See Wright (1993) 10 who is of the view that even where a contractual relationship exists between the medical man and his patient, "a duty in tort will exist." The writer continues to describe the concurrence of a duty in tort and a duty arising out of the contract when he states: "Thus in any case where there is a contract between the medical man and the patient there will exist side by side a duty in tort and a duty arising out of the contract." See also Jones (1996) 20 who recognizes the concurrence of the duty to take care arising from contract especially where "a doctor provides private treatment he or she also owes a concurrent duty in tort to the patient." See also Nelson-Jones and Burton (1995) 25-26; See further McHale and Fox (1997) 149 who recognize the "contemporaneous contractual duty" in addition to his/her tortious duty to take care.

Notwithstanding, the duty of care, being derived from contract or in tort or both, the nature of the duty, is the same, namely, to exercise reasonable care.⁴⁰

Generally the doctor's duty to exercise reasonable care does not include a successful outcome of the procedure or treatment nor does he/she guarantee the outcome, unless, the doctor has expressly guaranteed a particular result.⁴¹ Since, as previously stated, there is a concurrent duty in contract, as well as in tort, the patient's claim may be pleaded in both contract and in practice where there is a breach of such duty.⁴²

6.2.2.3 Case Law

One of the earliest recorded cases based on a malpractice action, bears the date 1329 and was decided by one of the King's Circuit Courts. Although the record is scanty and fails to provide the names of the Plaintiff and Defendant, nevertheless, Judge William De Demon was asked to hear this matter in which the Defendant, a healer of some sort, in treating an eye ailment with herbs, allegedly caused the loss of the eye. The Plaintiff brought this action, using the trespass writ but alleging that whilst the Plaintiff was under the care of the Defendant, the patient died. The Judge who decided the case found the case was *technically improper and found against the Plaintiff and stated:*

"I saw a case where a man in Newcastle was arraigned before me and my associate Justices assigned, for the death of a man, and I asked the reason for the indictment and it was said that he [physician] had injured a man [patient] who was under his care, so that he [patient] died four days later. When I saw that he [physician] was a man of that occupation, and did not do the thing feloniously but against his will, I told him to go on his way. I put

⁴⁰ See Jones (1996) 20 who states: *"The doctor's contractual obligations are usually no greater than the duties owed in tort."* See also Nelson-Jones and Burton (1995) 26 who opine that *"the courts have construed the implied contractual duty of care as identical to the duty of care owed in tort."* Commenting on the nature of the implied contractual duty of care and the duty which exists in tort, Wright (1993) 11 states: *"The duty is the same namely a duty to exercise reasonable care in the circumstances."* See also McHale et al (1997) 149 who express the view that: *"The duty is almost identical in substance in that the doctor is obliged to exercise reasonable care and skill."* See further Flemming *The Law of Torts* (1992) 167 - 169 who opine: *"There is no essential distinction, in the field of medical practise, between the duty of care and skill owed by the physician to his patient in contract and in the tort of negligence."* See further Kennedy and Grubb (1998) 291 who sees this as an indistinguishable duty.

⁴¹ See Jones (1996) 20; See further Nelson-Jones and Burton (1995) 26; Wright (1993) 11.

⁴² See Jones (1996) 24; although the writer recognizes the possibility that a doctor may guarantee a particular result, *"this is likely to be a rare occurrence."* See also Kennedy and Grubb (1994) 71-72; See further Jackson and Powell (1997) 592. The writers state that the English Court are generally loath to find that a doctor guaranteed a result as *"medicine is perhaps the classic example of a profession in which results are not guaranteed and are not expected to be guaranteed."* Despite that the authors recognize the possibility that a medical practitioner may *"in any given case contract that the proposed treatment will be successful."* See further Kennedy and Grubb (1996) 289. Although it is possible for the doctor to contractually to guarantee the outcome of the treatment, *"The doctor must use explicit and unequivocal words"* before a court will construe the contractual terms in favour of the patient.

*it to you that if a smith, who is [also] a man of occupation, drives a nail into your horse's hoof so that you lose your horse, you will never have recovery against him [smith]. Nor shall you have."*⁴³

From the judgement of Justice De Demon it can be inferred that from the physician or veterinarian's relationship with his or her patient a duty of care arises. Where the physician or veterinarian, acting within the usual professional relationship, injures or kills the patient (human being or horse) but does not intend to do so, he is not liable. For that reason negligent or ignorant conduct would, therefore, not impose liability.⁴⁴

In another case of *Stratton v Swanlond* (known as the surgeon's case of 1375), decided during the fourteenth century, the court highlighted *inter alia* the physician and veterinarian's duty to take care. In this case Robert and Agnes of Stratton, man and wife, sued John Swanlond, a surgeon, who had treated Agnes's wounded hand with unsatisfactory therapeutic results. The Plea Rolls of King's Bench say that Swanlond guaranteed "well and competently" to cure the wound, an allegation that he denied. Instead, he claimed, he reattached a hand that was virtually severed, but did not guarantee a cure. As in the Plea Roll account, the surgeon is also alleged to have been negligent and in breach of unwritten covenant.

Chief Justice John Cavendish using a horse-doctor analogy stated:

*"And if a smith undertakes to cure a horse, and the horse is harmed by his negligence or failure to cure in a reasonable time, it is just that he should be held liable. But if he does all he can and applies himself with all due diligence to the cure, it is not right that he should be guilty therefore, (even) though there is no cure."*⁴⁵

In a later judgement of *Slater v Baker and Stapleton*,⁴⁶ a surgeon in the employ of the St Bartholomew Hospital was sued for damages arising from his alleged negligent treatment of a patient. His conduct arose from the straightening of the patient's leg by using an experimental apparatus. The court finding in favour of the patient remarked: *"For anything that appears to the court, this was the first experiment made with the new instrument, and if it was, it was a rash action, and he who acts rashly acts ignorantly: and although the*

⁴³ See Chapman (1984) 56 for a discussion on the case.

⁴⁴ See Chapman (1984) 56.

⁴⁵ See Chapman (1984) 59 for a discussion on the court's shift in deciding the "Professional provider is liable if he is negligent and he does not employ 'all due diligence' in treating his patient", a far cry from Justice De Demon's earlier view that *"the physician is liable when injury or death results from treatment, only if he intends to do harm."*

⁴⁶ (1767) 95 ER 860.

defendants in general may be skilful in their respective professions as any two gentlemen in England, yet the Court cannot help saying, that in this particular case they have acted ignorantly and unskilfully, contrary to the known usage of surgeons." ⁴⁷

In a much later judgement in the case of *Lampher v Phipos*, ⁴⁸ Tindal CJ attributed the surgeon's duty of care to his skilled profession when he stated:

"Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not undertake, if he is an attorney, that at all events you shall gain your case, nor does a surgeon undertake that he will perform a cure, nor does he undertake to use the highest possible degree of skill." ⁴⁹

The use of some special skill or competence arising from the skilled medical professional also received the attention of the court in the case of *Bolam v Friern Hospital Management Committee* ⁵⁰ in which McNair J held:

"Where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art." ⁵¹

It has also been stated by the courts that no contractual relation is necessary for a duty of care to be imposed on the physician. In *R v Bateman* ⁵² it was stated that the physician:

"owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No contractual relation is necessary, nor is it necessary that the service be rendered for reward. The law requires a fair and reasonable standard of care and competence." ⁵³

The court goes on to state that the duty of care is rather attributed to the skilled profession when Lord Hewat remarked:

"If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such

⁴⁷ *Slater v Baker and Stapleton* (1767) 95 ER 860.

⁴⁸ (1838) 8 C @ P 475.

⁴⁹ *Lampher v Phipos* (1838) 8 C # P475.

⁵⁰ (1957) 1 WLR 582, 586.

⁵¹ *Bolam v Friern Hospital Management Commission* 1957 (1) WLR 582 586.

⁵² (1925) 94 L.J.K.B. 791.

⁵³ *R v Bateman* (1925) 94 L.J.K.B. 791.

*skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge.... "*⁵⁴

The principle that the duty to take care arises independently of contract, but is determined by the performance of the act, has also arisen in the case of *Everett v Griffiths*.⁵⁵

*"It would apply to a doctor treating a member of the household of the other party to the contract, as it would, in my judgement, apply to a doctor acting gratuitously in a public institution, or in the case of emergency in a street accident, and its existence is independent of the volition of the patient, for it would apply though the patient were unconscious or incapable of exercising a conscious volition."*⁵⁶

The duty of care may arise, especially in hospital cases, where, upon acceptance of the patient, the hospital authorities inherit a duty to treat the patient with care. This formed the subject matter in the case of *Cassidy v Ministry of Health*⁵⁷ in which Lord Denning remarked:

*"[W]hen hospital authorities undertake to treat a patient and themselves select and appoint and employ the professional men and women who are to give the treatment, they are responsible for the negligence of those persons in failing to give proper treatment, no matter whether they are doctors, surgeons, nurses, or anyone else. Once hospital authorities are held responsible for the nurses and or radiographers as they have been in Gold's case (Gold v Essex County Council 1942 2 ALL E.R. 237), I can see no possible reason why they should not also be treated as for the house surgeons and resident medical officers and their medical staff."*⁵⁸

After setting out the basis for the vicarious liability of the hospital, his Lordship continued to consider the aspect whether there was negligence or not. He continued:

"..... The hospital authorities accepted the plaintiff as a patient for treatment and it was their duty to treat him with reasonable care. They selected, employed, and paid all the surgeons and nurses who looked after him. He had no say in their selection at all. If those surgeons and nurses did not treat him with proper care and skill, then the hospital authorities must answer for it, for it means that they themselves did not perform their duty to him.

I decline to enter into the question whether any of the surgeons were employed only under a contract for services, as distinct from a contract of service. The evidence is meagre enough in all conscience on that point, but the liability of the hospital authorities should not, and does not, depend on nice considerations of that sort. The plaintiff knew nothing of the terms on which they employed their staff. All he knew was that he was treated in the hospital by people whom the hospital authorities appointed, and the

⁵⁴ *R v Bateman* (1925) 94 L.J.K.B. 791.

⁵⁵ (1920) 3 K.B. 163, 213; See also *Banbury v Bank of Montreal* (1918) A.C. 626 657.

⁵⁶ *Everett v Griffiths* (1920) 3 K.B. 163 213.

⁵⁷ (1951) 1 ALL E.R. 574; (1951) 2 K.B. 343; (1951) W.L.R. 147 Lord Denning cited his statement in two subsequent decisions namely *Roe v Minister of Health* (1954) 2 QB 66 and *Jones v Manchester Corporation* (1957) 2 ALL E.R. 125.

⁵⁸ *Cassidy v Ministry of Health* (1951) 1 ALL E.R. 574; 1051 2 KB 343; (1951) W.L.R. 147.

hospital authorities must be answerable for the way in which he was treated."⁵⁹

The doctor's general duty of care was also emphasized in the case of *Sidaway v Bethlem Royal Hospital Governors*⁶⁰ in which Lord Diplock relying on the Bolam test recognized the doctor's duty of care:

*"In English jurisprudence the doctor's relationship with his patient which gives rise to the normal duty of care to exercise his skill and judgment to improve the patient's health in any particular respect in which the patient has sought his aid, has hitherto been treated as a single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgement in the improvement of the physical or mental condition of the patient for which his services either as a general practitioner or specialist have been engaged."*⁶¹

6.2.2.4 Legal Opinion

(1) Although originally the doctor's duty of care arose from his status and common calling,⁶² this is no longer the position today, for the doctor/hospital/other healthcare provider's liability today, arises from a breach of contract,⁶³ alternatively from the general liability for the tort of negligence,⁶⁴ or both.⁶⁵

(2) The nature of the duty of care, whether derived from contract or in tort, is the

⁵⁹ *Cassidy v Ministry of Health* (1951) 1 ALL E.R. 574; 1951 2 KB 343; (1951) W.L.R. 147.

⁶⁰ (1985) AC 871; (1985) 1 ALL 643, 657.

⁶¹ *Sidaway v Bethlem Royal Hospital Governors* (1985) AC 871; (1985) 1 ALL 643 657.

⁶² Holdsworth *History of English Law* Vol. (iii) (1923) 385-386, Kennedy and Grubb *Principles of Medical Law* (1998) 285-286, Teff *Reasonable Care* (1995) 159-160, 173-180, Picard and Robertson *Legal Liability of Doctors and Hospitals in Canada* (1996) 1-3, Wright *Medical Malpractice* (1993) 6. For case law see *Lampher v Phipos* (1938) A C & P 475, *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 82.

⁶³ Legal writings in England, generally, advocate the existence of an implied contractual duty to act with due care and in the best interests of the patient. See Jackson and Powell *Professional Negligence* (1997) 592, Lewis *Medical Negligence* (1988) 123; Wright *Medical Malpractice* (1993) 7, Jones *Medical Negligence* (1996) 30, Dugdale and Stanton *Professional Negligence* (1989) 90, Scott *The General Practitioner and the Law of Negligence* (1995) 7.

⁶⁴ The duty of care is founded on the principle of assumpsit in that by undertaking to treat the patient the doctor/hospital assumes responsibility for the care, treatment or wellbeing of the patient, as the case may be see Wright *Medical Malpractice* (1997) 6, Kennedy and Grubb *Principles of Medical Law* (1998) 294, Nathan *Medical Negligence* (1957) 8, Kennedy and Grubb *Medical Law: Text with Materials* (1994) 68. For case law see *R v Bateman* (1925) 94 L.J. K.B. 791, *Everett v Griffiths* (1920) 3 K.B. 163, 213, *Banbury v Bank of Montreal* (1918) A.C. 626, 657, *Cassidy v Minister of Health* (1951) 1 ALL E.R. 574; (1951) 2 K.B. 343; (1951) W.L.R. 147, *Roe v Minister of Health* (1954) 7 QB 66.

⁶⁵ English legal writers generally recognize the concurrence of a duty in tort and in contract. See Wright *Medical Malpractice* (1997) 6, Jones *Medical Negligence* (1996) 20, Nelson-Jones and Burton *Medical Negligence Case Law* (1995) 25-26; McHale and Fox *Health Case Law* (1997) 149.

same, namely, to exercise reasonable care and skill. ⁶⁶

- (3) The doctor/hospital's duty to exercise reasonable care does not include a successful outcome of the procedure or treatment nor does he/she/it guarantee the outcome, unless, the doctor/hospital has expressly guaranteed a particular result. ⁶⁷

6.2.3 UNITED STATES OF AMERICA

6.2.3.1 Introduction

The American Common Law with regard to the doctor's duty of care towards his or her patient was very much influenced by English Law. ⁶⁸

Historically, as under early English Law, the liability of a physician for failure to exercise professional skill and care, in American Law, was based on the notion that the physician's profession was a "public" or "common" calling. ⁶⁹ The general public perceived those who entered this common calling to be reasonably competent in it. ⁷⁰

With the development of the American Law of Contract, the American Courts increasingly chose to assess the physician's liability in terms of contract concepts. ⁷¹

⁶⁶ Jones *Medical Negligence* (1996) 4, Jones *Medical Negligence* (1991) 19, Nelson-Jones and Burton *Medical Negligence Care Law* (1995) 25-26, Wright *Medical Malpractice* (1993) 11, McHale et al *Health Care Law* (1997) 149, Flemming *The Law of Torts* (1992) 167-169, Kennedy and Grubb *Principles of Medical Law* (1998) 291. See the dictum *Sidaway v Bethlem Royal Hospital Governors* (1985) AC871, (1985) 1 ALL 643, 657.

⁶⁷ Jones *Medical Negligence* (1996) 241; Jones *Medical Negligence* (1991) 19, Kennedy and Grubb *Principles of Medical Law* (1994) 71-72, Jackson and Powell *Professional Negligence* (1997) 592, Kennedy and Grubb *Principles of Medical Law* (1996) 289. Though the legal writers recognize the possibility that a doctor may guarantee a particular result, they are loathe to acknowledge the presence of such a guarantee unless clear evidence is present. For case law see *Lampher v Phipos* (1838) 8 C&O 475.

⁶⁸ See Peters et al *Law of Medical Practise in Michigan* (1981) 150. The authors claim the early American Courts very much looked to English Court decisions and legal values for precedential guidance.

⁶⁹ See Peters et al (1981) 150 The authors opine that the philosophy behind the liability arising from the common calling is founded in the common calling and because the public was being served which result in "*special duties were imposed by law and the physician was answerable for mistakes, because the physician undertook the care of the patient in the course of a public calling.*"

⁷⁰ See Shea and Sidley *Law and Ethics* (1985) 183 quoting from Fitzherbert (1534) who summarized the position as "*it is the duty of every artist to exercise his art rightly and truly as he ought.*" See further Arterburn: "The Origin and First Test of Public Callings" *University of Pennsylvania Law Review* Vol. 75 (1927) 411 412. See further Silver: "One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice" (1992) *Wisconsin Law Review* 1193, 1205. The author opines that "*the medieval medical malpractice cases were thus based on negligence and little else.*"

⁷¹ See Peters et al (1981) 150.

The development in the law of contract in America was accompanied by another development in the United States, namely, the moving away from assessing the physician's liability based on the traditional physician's supposed duties to possess such skill as is normally possessed by others of his calling, towards the concept of reasonable care with customary medical practice equated with it.⁷²

The fore stated transformation caused negligence to receive a distinct judicial recognition as a separate tort, causing the historical liability of a physician based on the notion of the physician's professional calling to become extinct.⁷³

Today, the first requirement in establishing negligence is for the plaintiff to prove the existence of a legal relationship between him- or herself and the defendant.⁷⁴

Arising from the legal relationship between the parties concerned is a duty, generally referred to as a duty to use due care.⁷⁵

The duty may arise from a special relationship, as for example, the relationship between a physician and a patient.⁷⁶

The duty to use due care may arise out of a physician's voluntary act of assuming the care

⁷² See Silver (1992) 1212-1213. The writer points out that in the latter half of the nineteenth century with the development as afore indicated the common law position with regard to medical malpractice changed in that *"the common law then purported to provide that a physician's duty is not measured by the ordinary rule of reasonableness, but rather by professional custom. The doctor is bound to do no more than follow ordinary practise within the profession."* See also Peters et al (1981) 150 who states that *"..... approximately a century and a half ago, negligence received a distinct judicial recognition as a separate tort"* in which *"the reasonable man's standard is modified for medical malpractice actions in mal-practitioner which negligence is determined by comparing the behaviour (acts or omissions) of the alleged medical with that of the reasonable and prudent practitioners of medicine."*

⁷³ Peters et al (1981) 150.

⁷⁴ Pozgar *Legal Aspects of Health Care Administration* (1996) 14.

⁷⁵ See Pozgar (1996) 14. The author defines the duty as *"a legal obligation of care, performance or performance imposed on one to safeguard the rights of others."* The legally protected rights in America for the last 600 years according to Hoffman in the chapter on "Torts" published in the *American College of Legal Medicine - Legal Medicine* (1991) 41 are based on *"the individuals person, property and reputation which must not be interfered with or invaded."*

⁷⁶ See Pozgar (1996) 14. See also the *American College of Legal Medicine* (1991) 43 119; See further Shear and Sidley *Law and Ethics* (1985) 184. The author states: *"By virtue of his special relationship to patients, the health professional owes to patient's a special degree of protection from harm. He must protect others from deficiencies in the practice of his profession by adhering to the standards of the profession."*

of a patient ⁷⁷ or by statute ⁷⁸ or by contract between the physician and patient. ⁷⁹

6.2.3.2 Legal Writings

⁷⁷ See Voigt - "Physician-Patient Relationship" A Chapter published in the *American College of Legal Medicine* (1991) 208. The author states that as general rule physicians are not legally compelled to treat strangers. What is required is the creation of a physician-patient relationship or some other special relationship. In the so-called "sidewalk" cases when the physician voluntarily assumes the care of a patient, the physician owes a duty of due care to the patient. Contra Holder *Medical Malpractice Law* (1975) 7. The author states that as a general rule a physician in private practice has the right to refuse to see a patient, although if he sees the patient at all in the case of an emergency, he must provide at least temporary care. This approach aligns itself with the so-called "good Samaritan law" principle. See Alton *Malpractice* (1977) 29. The author opines that this principle "*is designed to encourage physicians to treat injured persons they encounter in emergency situations.*" Once the physician has assumed the care of a patient he is seized with that patient until the physician is sure someone qualified has taken over or until the emergency situation no longer exists. See further Peters et al (1981) 153-154; See further Moore and Kramer *Medical Malpractice: Discovery and Trial* (1990) 5. The authors express the view that hospital's, likewise, are under no obligation or duty to render services until an agreement to treat has been reached between the hospital authorities and the patient. Where, however, there is an emergency, "*the physician is connected with a governmental agency, hospital, or medical facility that has a specific obligation to treat members of the public; or a hospital physician is required to accept all patients referred without qualification.*"

⁷⁸ See Waltz and Inbau (1971) 17 ; The authors express the view that as "*the medical profession and the general public, obviously, have a deep and continuing interest in the quality of medical and related health services, one way of doing so is to regulate the quality of vital services.*" The physicians and hospital's duty of care is therefore controlled by professional canons of ethics, licensing laws, criminal laws prohibiting and punishing unauthorized practice of medicine, regulations, common law standards of professional conduct enforced by the courts, etc. It is especially the licensing laws which Waltz et al (1971) 18 views as a control mechanism exercised by the Government to promote "public health, welfare and safety" and which are designed to "protect the public from incompetent and unethical practitioners". According to the authors (1971) 19 licensing laws have also been put in place to regulate the minimum qualifications of physicians as well as there standards of conduct for entry into and retention of those in the occupation. It further provides for license revocation or suspension in respect of both physicians and hospitals in certain circumstances. The American Medical Association in their *Principles of Medical Ethics* (1957) also promote physicians/hospital's duty of care by setting standards of proficiency and propriety which are according to Waltz et al (1971) 29 as demanding as the licensing statutes. Sections 1, 4, 6 of the Principles of Medical Ethics (1957) read as follows: "*Section 1: The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.*" "*Section 4: The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honour of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.*" "*Section 6: A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.*" See also Sanbar et al (1995) 7 - 8.

⁷⁹ The duty of care according to Holder (1975) 3 may arise from an express contract between the physician/hospital and patient. The duty of care is however, not dependant on an express agreement. In certain instances the duty arises from an implied contract. Holder (1975) 3 ascribes the existence of the duty as that which may be "*inferred by the law as a matter of reason and justice from their acts or conduct.*" See also Waltz et al (1971) 40 - 41; See further Furrow et al (1995) 234 - 236; Crawford Morris and Moritz (1971) 135; Hill and McMenamin "Contracts, Agency and Partnership" A chapter in *American College of Legal Medicine, Legal Medicine* (1991) 62 - 63; Sidley (1985) 183. See further Peters et al (1981) 150 - 151. The authors describe an implied contract as "*not a true contract it is an obligation imposed by law, to do justice in respect of activities engaged in by the physician and the patient.*" See further Moore and Kramer (1990) 4 - 5; See also Southwick and Sleep *The Law of Hospital and Health Care Administration* (1988) 29.

American Legal writers generally agree that a physician/hospital's liability for medical malpractice arises from either a breach of contract⁸⁰ or in tort.⁸¹

The contract between the physician and patient may either be express⁸² or implied.⁸³

There is a broad consensus amongst American writers that whether the physician/hospital enters into a contract with a patient or not, what flows from their relationship when the physician/hospital accepts the patient as a patient is a duty of care.⁸⁴

⁸⁰ See Waltz and Inbau (1971) 50 who advocate that: *"The physician-patient relationship is ordinarily considered to be based on contract, express or implied."* See also Furrow et al (1995) 234; See further Sanbar et al (1995) 62 - 63; See further Voight "Physician-Patient Relationship" published in *American College of Legal Medicine* (1991) 208 - 209. The author states that: *"From the traditional physician-patient relationship which is based on the nature of the relationship, is implied a contract between the physician and patient."* See further Holder (1975) 1. The author relying on the physician-patient relationship opines that: *"It is generally considered to be a contractual one"* See further Sidley (1985) 183; See further Southwick and Slee (1988) 28 -29.

⁸¹ See Waltz and Inbau (1971) 40; the authors state that in certain instances *"claims against physicians are usually expressly in terms of negligent conduct."* In other words: *"The plaintiff claims not that the defendant violated their contract but that he committed a `tort'."* See also Furrow et al (1995) 237 who opine that: *"The liability of health care providers is governed by negligence principles."* See further *American College of Legal Medicine* (1991) 43 119 130 132. See further Holder (1975) 40. The author regards negligent actions as species of "tort" law, which is defined as: *"A violation of a duty imposed by general law or otherwise upon all persons occupying the relation to each other which is involved in a given transaction."* See further Southwick and Slee (1988) 52.

⁸² Express agreements between physician and patient according to American writers are not formalistic in nature. Writing is also not a prerequisite in establishing a legal relationship between the physician and patient. See Furrow et al (1995) 235. See also Waltz and Inbau (1971) 40 who expresses the view that: *"Occasionally the contract between the doctor and patient may be a formal, written contract."* Hill and McMenam in the chapter "Contracts, Agency, and Partnership" published in *American College of Legal Medicine* (1991) 63 opines that expressed contracts have been utilized in the past where doctors have made *"an expressed promise to perform a specific procedure, cure the patient within a specific time, or achieve a certain result."* See further Bianco and Hirsh "Consent to and Refusal of Medical Treatment" published in *American College of Legal Medicine* (1991) 274. The authors opine that it is especially in hospital contracts that expressed consent occurs which are often in writing. See further Moore and Kramer (1990) 5.

⁸³ Implied agreements between the physician and patient are the most common form in the physician-patient relationship. See Waltz and Inbau (1971) 40 – 41; The authors states that usually: *"The agreement simply arises by implication from the behaviour of the parties for example a person who places himself in the hands of a private physician for treatment implies a willingness to pay for the services he receives, and the physician, of course, impliedly undertakes to perform competently the services required by any patient he accepts."* See also Furrow et al (1995) 235. The authors state that when a pathologist accepts to render services he is bound by certain implied contractual obligations to properly perform his or her medical function. See also Holder (1975) 3; See further Sidley (1985) 183; See further Peters et al (1981) 151; Southwick and Slee (1988) 23.

⁸⁴ See Waltz and Inbau (1971) 41; the authors express the view that: *"The duty towards the patient is a duty which the law imposed on the physician a standard of care."* The nature of the physician's legal duty towards his/her patient is expressed as follows by Waltz and Inbau (1971) 42 namely: *"A physician has the obligation to his patient to possess and employ such reasonable skill and care as are commonly had and exercised by reputable, average physicians in the same general system or school of practice in the same or similar localities."* The duty imposed upon the physician according to Southwick and Slee (1988) 28 are: *"A special legal duty which arises from the physician-patient relationship."* See also Furrow et al (1995) 237 who describes the legal duty of the

6.2.3.3 Case Law

In America the inherent duty or implied duty of a doctor's obligations towards his patient, in the absence of a contractual agreement, is set out in the landmark decision of *Pike v Honsinger*⁸⁵ which down the years has been followed quite regularly by other courts. In this decision the court held: "A physician and surgeon, by taking charge of a case, impliedly represents that he possesses, and the law places upon him the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed by surgeons and physicians in the locality in which he practices, and which is ordinarily regarded, by those conversant with the employment, as is necessary to qualify him to engage in the business of practicing medicine and surgery. Upon consenting to treat a patient, it becomes his duty to use reasonable care and diligence in the exercise of his skill and the application of his learning to accomplish the purpose for which he was employed. He is under the further obligation to use his best judgement in exercising his skill and applying his knowledge. The law holds him liable for an injury to his patient resulting from want of the requisite skill and knowledge or the omission to exercise reasonable care or failure to use his best judgement....." ⁸⁶

The principle enunciated in the case of Pike was extended by the Supreme Court of Indiana in 1938, in the case of *Adkins v Ropp*⁸⁷ in which the court held: "When a physician and

physician towards his/her patient: "*Expressing the required degree of care, skill and diligence.*" See also Morris and Moritz (1971) 135. Hospitals according to Furrow et al (1995) 297 are generally held to a national standard of care in "*maintaining its facilities, providing and maintaining medical equipment, hiring, supervising and retaining nurses and other employees, and to have in place providing to protect patients.*" See also Ferger "Liability of Health Care Entities for Negligent care" a chapter published in *American College of Legal Medicine* (1995) 157. See further Hoffman in the Chapter on "Torts" in the *American College of Legal Medicine* (1991) 43 who described the legal duty of physicians and hospitals as: "*The standard established by law for the protection of others.*" See further Holder (1975) 40 - 41. Flamm in the chapter "Health Care Provider as a Defendant" published in *American College of Legal Medicine* (1995) 119 132 described the legal duty of the physician as: "*A duty to act in accordance with the specific norms or standards established by their profession, commonly referred to as "standards of care" to protect their patient's against unreasonable risk.*" See further Shea and Sidley (1985) 183. Peters et al (1981) 151 153; see further Moore and Kramer (1990). The authors view the legal duty of the physician as: "*The responsibility to assume the welfare of his patient in all phases of his treatment.*" McClellan *Medical Malpractice Law: Tactics and Ethics* (1983) 31 48 suggests that as it often poses a threshold problem for the courts to compare the conduct of the physician, the modern trend "*is to apply a national standard of care to doctors, especially those practicing in a medical specialty.*"

⁸⁵ 49 NE 760 New York (1898).

⁸⁶ *Pike v Honsinger* 49 NE 760 New York (1898). For cases in which the dictum of Pike was followed see *Gillette v Tucker* 67 Ohio St 106 (1902); *Rytkonen v Lojacano* 269 Mich 270 (1934); See also *Keuchler v Volgmann* 180 Wisc 192 (1923) in which it was held: "The rule is that a physician is required to exercise only that degree of care, diligence, judgement and skill which other physicians of good standing of the same school or system of practise usually exercise in the same or similar circumstances, having due regard to the advanced state of the medical profession at the time in question."

⁸⁷ 14 NE 2d 727 Indiana 727 (1938).

surgeon assumes to treat and care for a patient, in the absence of a special agreement, he is held in law to have impliedly contracted that he possesses the reasonable and ordinary qualifications of his profession and that he will exercise at least reasonable skill, care and diligence in his treatment of him. This implied contract on the part of the physician does not include a promise to effect a cure and negligence cannot be imputed because a cure is not effected, but he does impliedly promise that he will use due diligence and ordinary skill in his treatment of the patient, so that a cure may follow such care and skill, and his degree of care and skill is required of him not only in performing an operation or administering first treatments, but he is held to the like degree of care and skill in the necessary subsequent treatments unless he is excused from further service upon due notice by the patient himself." ⁸⁸

Sometime later in the case of *Armstrong v Svoboda* ⁸⁹ the Supreme Court of California heard a medical negligence case and emphasized the duty of care which the medical practitioner owes his patient. The facts of this case can briefly be stated as follows:

An electrocardiogram made when a patient complained of chest pains indicated possibly serious cardiac abnormalities. The physician did not tell the patient anything about the results, nor did he prescribe rest or any treatment. A week later, when the chest pains recurred and were worse, the patient called him and the physician told him to go to the hospital. He did not, however, tell him to go in an ambulance, so the patient walked down several flights of stairs and rode to the hospital in his car. Examination revealed that he had had a heart attack several days before. Open heart surgery was required to repair the damage. He sued and recovered damages from the physician.

The court subsequently held that the physician did not exercise due care in that: *"... a duly careful, reasonably prudent physician would have told his patient about the electrocardiogram results and would have hospitalized him immediately."*

Although the courts in the United States of America have continuously held that the physician owes his patient a duty of care, the standard of care has never included the working of miracles or total success whenever treatment is undertaken. In the absence of an express contractual promise, the physician is not considered a guarantor of good results.

⁸⁸ *Adkins v Ropp* 14 NR 2d 727 Indiana 727 (1938).

⁸⁹ 49 CAL RPTR 707, CAL 1966.

In a case in Kansas the Supreme Court of Kansas in *Noel v Proud*⁹¹ upheld the trial judge's refusal to dismiss the Appellant's case. The facts of the case can briefly be stated as follows: The physician Proud undertook the treatment of plaintiff Noel for ear trouble, advising him that he should undergo stops mobilization operations. But Doctor Proud, for some reason, went further. He allegedly told his patient that "while the operations might not have any beneficial effect on [his- hearing, his hearing would not be worsened as a result." Three operations were performed. Not only did Noel's hearing fail to improve, it got much worse. He sued his doctor alleging the breach of an express contractual warranty that his hearing would not worsen as a consequence of the operations.

The court consequently found for the Appellant on the basis that the facts relied upon by the Appellant supported that the Respondent guaranteed a result which ultimately was not achieved.

A breach was also found to have occurred in the case of *Ghilmet v Campbell*⁹² in which the doctor promised a particular result which failed to materialize. In this case the physician treated the patient for a bleeding ulcer. The physician had allegedly told the patient prior to the operation: "*Once you have an operation it takes care of all your troubles. You can eat as you want to, you can drink as you want to, you can go as you please. Dr Arena and I are specialists, there is nothing to it at all - it's a very simple operation. You'll be out of work three to four weeks at most. There is no danger at all in this operation. After the operation you can throw away your pill box.*"⁹³

The patient suffered serious after-effects. The court subsequently found for the plaintiff on the basis that the physician had breached the agreement in which he guaranteed a result.

By embarking upon treatment, the physician by implication or impliedly represents that he has the necessary training, knowledge and skill and that he/she will employ these assets in the way any reputable physician ordinarily would.⁹⁴

⁹⁰ *Armstrong v Svoboda* 49 CAL RPTR 701, CAL 1964.

⁹¹ 367 P 2d 61 (S.Ct. Kans 1961. See also *Ramberg v Morgan* 218 N.W. 492 (S.CT.IOWA 1928); *Williamson v Andrews* 270 N.W. 6 (S.CT.MINN 1936); *McBride v Roy* 58 P. 2d 886 (S.CT.OKLA 1936).

⁹² 188 N.W. 2d 601 (Mich 1971).

⁹³ *Guilmet v Campbell* 188 N.W. 2d 601 (MICH 1971).

⁹⁴ *Richton v Sargent* 27 NH 460 (S.CT.NH 1853), *McLandless v Mowha* 22 PA (10 HARIS) 261 (S.CT. PA 1853).

The duty of care may also require the prudent and careful physician to consult with other medical practitioners including a physician who may previously have treated the patient. This was the issue in the case of *Largess v Tatem*⁹⁵ in which the following facts came to light namely:

An elderly woman broke her hip. Her family physician, a general practitioner, referred her to an orthopaedic surgeon, who inserted a nail in the fracture. The orthopaedist took over her care while she was in the hospital but returned her to the supervision of the family physician when she was dismissed. The general practitioner knew that the orthopaedist's instructions during hospitalization excluded weight-bearing, but he made no inquiry of the orthopaedist as to instructions for himself or the patient at the time of dismissal. She walked on the affected leg since she had had no instructions to the contrary. The device broke and further surgery became necessary. She sued the family doctor. The court found that he failed in his duty of due care when he did not consult with the orthopaedist as to instructions in the case.

The court found that the physician had failed in his duty of care when he did not consult with the orthopaedist when it was indicated.

In a similar case in that of *Langford v Kosterlitzo*⁹⁶ the High Court of California was asked to consider whether the physician's failure to consult with a surgeon who had previously operated on the patient constituted negligence. In this case the facts that played out are the following:

A patient had a piece of bone removed from his nose and his optic nerve was unprotected. He consulted another physician a considerable time after surgery for treatment of asthma. He told the second physician about the nasal surgery and the name of the surgeon who had performed it. The second physician did not call the surgeon to inquire about the operation or any of its effects. During his treatment of the asthmatic condition, the optic nerve was damaged and the patient lost the sight of that eye. The court held that the physician's failure to consult with the prior surgeon before beginning treatment constituted negligence.

The court consequently held that the physician's failure to consult with the prior surgeon before beginning to treat the patient, when indicated, constituted negligence.

The physician's duty of care, in some instances, also embraces the referral of the patient to a specialist for diagnosis or treatment and to allow the specialist to take over in cases which so warrant, the failure whereof constitute negligence.⁹⁷

⁹⁵ 211 A 2d 398 VT. 1972.

⁹⁶ 290 PAC 80, CAL 1930.

⁹⁷ *Logan v Field* 75 Mo APP 594, Mo 18 98; *Benson v Dean* 133 NE 125, NY 1921.

One of the most important duties a physician and/or a hospital owes his patient under the general concept of due care is the doctor/hospital obligation to keep abreast of new developments in medicine. In the first case of *Darling v Charleston Community Memorial Hospital*,⁹⁸ involving a hospital in Illinois, the hospital was held liable for the negligence of one of its staff physicians who set a fractured leg in an emergency. The physician admitted, at the trial, that he had not read a book on orthopaedics in 10 years, but, he had not asked for consultation when obvious postoperative signs of difficulties developed.

In the second case, *Reed v Church*,⁹⁹ involving a doctor and in which medication permanently affected a patient's eyesight. Medical literature had contained numerous articles indicating the possibility of such a side effect but, the physician, who prescribed it, had not read any of the articles. The court consequently found that he was negligent in failing to keep up with and be aware of developments in the field.

6.2.3.3 Legal Opinion

- (1) The doctor's duty of care towards his or her patient which serves as a protective measure in preventing harm to the patient and to act in the patient's best interests, is very much recognised by the American legal writers and the American courts, alike.
- (2) The duty of care towards the patient is said to arise from different notions inter alia:
 - (2) (1) The special relationship between a physician and a patient results in the creation of a protective bond between the physician and the patient in which the physician is obliged to protect the patient from harm and, in so doing, to adhere to the standards of the profession.¹⁰⁰
 - (2) (2) there are other critics who advocate that the duty of care between the physician/hospital and the patient only comes into being when the

⁹⁸ 200 NE 2d 149, III NE 2d 253, III 1965.

⁹⁹ 8 SE 2d 285, LA 1940.

¹⁰⁰ See Pozgar *Legal Aspects of Health Care Administration* (1996) 14, Sidley *Law and Ethics* (1985) 184; Waltz and Inbau *Medical Jurisprudence* (1971) 17, Southwick and Slee *The Law of Hospital and Healthcare Administration* (1988) 29, Furrow et al *Health Law* (1995) 237, Morris and Moritz *Doctor and Patient and the Law* (1971) 135, Hoffman in the Chapter on "Tort" in the *American College Legal Medicine* (1991) 43, Holder *Medical Malpractice Law* (1975) 40-41; Flamm in the Chapter "Health Care Provider as a Defendant" Published in the *American College of Legal Medicine* (1995) 119 12. According to the writers, both physicians and hospitals have the duty towards their patients and to act in accordance with the specific norms or standards established by the profession in respect of physicians and the accreditation system and licensing practises in respect of hospitals.

physician/hospital has assumed the care of the patient.¹⁰¹

(2) (3) the duty of care arises in terms of the provisions of certain statutes designed to promote public health, welfare and safety.¹⁰²

(2) (4) the physician/hospital's duty of care is said to also arise by contract express or implied, between the physician/hospital and the patient.¹⁰³

(2) (5) Even in the absence of a contractual agreement between the doctor/hospital and the patient, it is advocated that the duty of care nevertheless arises from the mere relationship between the physician/hospital and the patient.¹⁰⁴

¹⁰¹ This notion finds its existence in the general rule which prevails in America namely physicians/hospitals are not legally compelled to treat strangers save in emergency situations. See Vogt "Physician-Patient Relationship" A Chapter published in the *American College of Legal Medicine* (1991) 208, Holder *Medical Malpractice Law* (1975) 7, Alton *Malpractice* (1977) 29, Peters et al *The Law of Medical Practise in Michigan* (1981) 153-154, Moore and Kramer *Medical Malpractice: Discovery and Trial* (1990) 5.

¹⁰² The medical profession in America with its accompanying standards of conduct, minimum qualifications for physicians, licensing laws and professional canons of ethics is very much governed by regulations and statutory provisions. The rationale behind the regulations, statutory provisions and canons of ethics is to promote the physician's/hospital's duty of care by setting standards of proficiency and propriety. See Waltz et al *Medical Jurisprudence* (1971) 17-19, 29; Sanbar et al *Legal Medicine* (1995) 7-8, See also the American Medical Association *Principles of Medical Ethics* (1957) 54ff.

¹⁰³ For a duty of care arising from an express contract see Holder *Medical Malpractice Law* (1975) 3, Furrow et al *Health Law* (1995) 235, Waltz and Inbau *Medical Jurisprudence* (1971) 40, Hill and Momenamin "Contracts, Agency and Partnership" A Chapter published in the *American College of Legal Medicine* (1991) 63. Bianco and Hirsh "Consent to and Refusal of Medical Treatment" A Chapter published in the *American College of Legal Medicine* (1991) 274, Moore and Kramer *Medical Malpractice: Discovery and Trial* (1990) 5. The advantage of expressed agreements in relation to the doctor/hospital's duty of care is said to be, it produces certainty as to what procedure will be followed, what treatment is prescribed and what results are aimed at. The duty of care, in the absence of an express agreement, arises impliedly from the contract entered into between the hospital/physician and the patient. The implied agreement is often inferred from the conduct of the doctor/hospital and the patient. See Waltz and Inbau *Medical Jurisprudence* (1971) 40; Furrow et al *Health Law* (1995) 235; Holder *Medical Malpractice Law* (1975) 3; Sidley *Law and Ethics* (1985) 183; Peters et al *The Law of Medical Practise in Michigan* (1981) 151; Southwick and Slee *The Law of Hospital and Healthcare Administration* (1988) 23.

¹⁰⁴ The duty of care in these circumstances is said to be a duty which the law imposes upon the physician/hospital. See Waltz and Inbau *Medical Jurisprudence* (1971) 41, Southwick and Slee *The Law of Hospital and Healthcare Administration* (1988) 28. Furrow et al *Health Law* (1995) 237, Morris and Moritz *Doctor and Patient and The Law* (1971) 135, Hoffmann in the Chapter on "Torts" in the *American College of Legal Medicine* (1991) 43, Holder *Medical Malpractice Law* (1975) 40-41, Flamm in the Chapter "Healthcare provider as a Defendant" published in the *American College of Legal Medicine* (1995) 119 132, Shea and Sidley *Law and Ethics* (1985) 183, Peters et al *The Law of Practise in Michigan* (1981) 151-153, Moore and Kramer *Medical Malpractice: Discovery and Trial* (1990) 7. It is a legal duty aimed at the protection of the public against the impropriety of physicians and hospitals. The inherent duty or implied duty of a physician in the absence of a contractual agreement is dealt with in the landmark decision of *Pike v Hosinger* 49 NE 760 New York (1998) in which the

3. The nature and scope of the doctor's/hospital's duty of care towards his/her patient is said to include the following:
- (3) (1) the duty of care has never included the working or miracles or total success wherever treatment is undertaken. ¹⁰⁵ This, of course, is subject to the physician/or surgeon not warranting or guaranteeing a result. Should he/she, however, guarantee a result and fails to achieve the guaranteed result, the physician/or surgeon will be liable for damages based on breach of contract.¹⁰⁶
 - (3) (2) the duty of care includes that by embarking upon the treatment of the patient, the physician gives out that he/she has the necessary training, knowledge and skill which he/she will utilize in treating the patient. ¹⁰⁷
 - (3) (3) in certain instances, where the situation so warrants, the physician is obliged to consult ¹⁰⁸ the medical practitioners including a practitioner who may previously have treated the patient. ¹⁰⁹
 - (3) (4) Where the case so indicates, there is a duty on the physician to refer the patient to a specialist.
 - (3) (5) the physician surgeon is obliged to keep abreast of new developments in medicine. ¹¹⁰

court held that by the mere fact that the physician and surgeon taking charge of a case, the physician and surgeon inherits a duty to use reasonable care and diligence towards the patient. See also the case of *Adkins v Ropp* 14 NE 2d 727 Indiana 727 (1938). For other cases in which the implied duty of the physician is dealt with see *Gillette v Tucker* 67 OHIO ST 106 1902, *Rytkonen v Lojacano* 269 MICH 270 (1934), *Keuchler v Volgman* 180 WISC 192 1923, *Armstrong v Svoboda* 49 CAL RPTR 701, CAL 1966.

¹⁰⁵ It has been held on numerous occasions by the American courts that physicians are not considered as guarantors of good results. See *Ramberg v Morgan* 218 N W 492 (S.CT.IOWA 1928); *Williamson v Andrews* 270 N.W. 6 (S.CT.MINN 1936), *McBride v Roy* 58 P. 2d 886 (S.CT.OKLA 1936).

¹⁰⁶ *Noel v Proud* 367 P. 2d 61 (S.CT.KANS 1961); *Guilmet v Campbell* 188 N.W. 2d 601 (MICH 1971).

¹⁰⁷ *Leighton v Sargent* 27 NH 460 (S.CT.NH 1853); *McLanders v Mcwha* 22 (10 Haris) 261 (S.CT.PA 1957).

¹⁰⁸ *Largess v Tatem* 211 A 2d 398 VT 1972; *Langford v Kosterlito* 290 PAL 80, CAL 1930.

¹⁰⁹ *Bolam v Field* 75 MO APP 594, MO 18 1898; *Denson v Dean* 133 NE 125, NY 1921.

¹¹⁰ *Darling v Charleston Community Memorial Hospital* 200 NE 2d 149, 211 NE 2d 253 ILL 1965; *Reed v Church* 8 SE 2d 285 LA 1940.

6.3 THE DOCTOR'S/HOSPITAL'S STANDARD OF CARE

6.3.1 SOUTH AFRICA

6.3.1.1 Legal Writings

It is generally accepted amongst legal writers that, as the work of the doctor/hospital requires some form of skill, the standard of care required of the medical practitioner is upgraded, in that, the medical practitioner engages in an activity calling for expertise.¹¹¹

In the light of the above, the criteria used in measuring the conduct of the medical practitioner are no longer an objective test, in which the hypothetical or fictitious reasonable person sets the standard.¹¹² The criteria applied have shifted to a more subjective test, in which the reasonable doctor in the same position as the individual doctor sets the standard.

The criteria used for measuring the conduct of the medical practitioner are that of the reasonable expert - the reasonable practitioner or the reasonable specialist whichever branch of the medical field is applicable.

In deciding the question of reasonableness, our courts have regard to the meaning attached thereto by our legal writers.¹¹³

The test for the standard of care expected of a medical practitioner is often formulated as:

¹¹¹ See Boberg (1984) 346; McKerron (1971) 38; Neethling Potgieter and Visser (1996) 133; Van der Merwe and Olivier (1989) 142; Van der Walt (1979) 70; Van Oosten (1996) 81 - 82; See further Carstens and Pearmain (2007) 619.

¹¹² Boberg (1984) 346. The author formulates the ratio for the shift in the criteria 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."* See further Carstens and Pearmain (2007) 619ff.

¹¹³ See Van Oosten (1996) 82 who defines reasonableness in the medical context as: *"Not the highest possible degree of professional care and skill"* and further *".... the standard is thus based not on what can be expected of the exceptionally able doctor" but ".... 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."* See also Gordon Turner and Price (1953) 110; Strauss (1984) 36ff; See further Strauss and McQuiod-Mason LAWSA (1983) 151. The author describes 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 also Dada and McQuiod-Mason (1983) 21 -22; See further Strauss (1991) 95. The author takes the view that the duty of care of a doctor is *"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."* Carstens and Pearmain (2007) 619ff.

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.¹¹⁴

6.3.1.2 Case Law

One of the first cases, in South Africa, in which the court was asked to deal with the degree of skill and care required of a medical practitioner, is to be found in the Cape decision of *Lee v Schonberg*.¹¹⁵ Relying heavily on an English decision of *Lampher v Phipos*, De Villiers CJ lays 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."*¹¹⁶

In a later decision of *Kovasky v Krige*¹¹⁷ the court was again called upon to pronounce upon the degree of skill and care expected of a medical practitioner. Sir John Buchanan also relied upon the English decision of *Lampher v Phipos* when he remarks:

*"The principles there lay down have been applied in this court, and with them I entirely agree. As to capacity, Chief Justice Tindal 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 his case."*¹¹⁸

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*¹¹⁹ 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

¹¹⁴ See Dada and McQuoid-Mason (2001) 23; See also McQuoid-Mason and Strauss (1983) 151; Carstens and Pearmain (2007) 619ff.

¹¹⁵ (1877) 7 BUCH 136.

¹¹⁶ See *Lee v Schönberg* (1877) 7 BUCH 136.

¹¹⁷ (1910) 20 CTR 822.

¹¹⁸ See *Kovalsky v Krige* (1910) 20 CTR 823.

¹¹⁹ 1914 AD 519 at 525.

of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not." ¹²⁰

The fore stated principle has also been followed in a host of latter judgements. ¹²¹

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* ¹²² in which 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'. 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. The evidence of qualified surgeons or physicians is of the greatest assistance in estimating that general level."

And further: Wessel, J.A. said:

"We cannot determine in the abstract whether a surgeon has or has not exhibited reasonable skill and care. We must place ourselves as 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." ¹²³

The said general 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*: ¹²⁴

¹²⁰ *Mitchell v Dixon* 1914 AD 519 at 525.

¹²¹ *Coppen v Impey* 1916 CPD 309 at 314; *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) 723 - 724; *Buls 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).

¹²² 1924 (AD) 438 at 444.

¹²³ *Van Wyk v Lewis* 1924 (AD) 438 at 444.

¹²⁴ 1948 (4) SA 349 (C) 461 to 462; See also *Webb v Isaac* (1915) 275, 276, 278, 279; *Coppen v Impey* 1916 CPD 309 at 314; *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) 723-724; *Buls v Tsatsarolakis* 1976

"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 his patients, would be required to exercise in certain circumstances a greater degree of care and caution than in other circumstances." ¹²⁵

The degree of skill expected of a medical practitioner was also defined as follows in *R v Van der Merwe* ¹²⁶ 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." ¹²⁷

As to what constitutes reasonableness, in the same judgement Roper J, remarks:

"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." ¹²⁸

The same principle applies also to anyone else who performs a medical function ¹²⁹ and is not only restricted to medical practitioners.

6.3.1.3 Legal Opinion

(1) It is generally accepted by our legal writers ¹³⁰ and our courts ¹³¹ that, as the work

(2) SA 891 (T) 893-894; *Byrne v East London Hospital Board* 1926 EDL 126 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).

¹²⁵ *R v Van Schoor* 1948 (4) SA 349 (C) 350.

¹²⁶ 1953 (2) PH H 124 (W).

¹²⁷ *R v Van der Merwe* 1953 (2) PH H 124 (W).

¹²⁸ *R v Van der Merwe* 1953 (2) BH H 124 (W).

¹²⁹ In the case of *S v Mahlalela* 1966 (1) SA 226 (A) the accused was a herb doctor who had concocted a herb mixture which he had administered to the deceased, a 7-year old girl, as a consequence of which, she died due to vegetable poisoning and who was subsequently convicted of culpable homicide. The Court subsequently held that the accused, by reason of his profession as a herb doctor, acquired sufficient knowledge of the nature and qualities of the trees and plants from which he extracted herb medicine, occupied the position of a reasonable expert, who would have known the herb mixture to be poisonous and would have foreseen death as a possible consequence of his conduct.

¹³⁰ See Boberg *The Law of Delict* (1984) 346; McKerron *The Law of Delict* (1971) 38; Neethling Potgieter and Visser *Deliktereg* (1996) 133; Van der Merwe and Olivier *Die Onregmatige Daad in die Suid-Afrikaanse Reg* (1989) 142; Van der Walt *Delict: Principles and Cases* (1979) 70; Van Oosten *Encyclopaedia* (1996) 81-82; Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 619ff.

of a doctor and specialist require some form of skill, the standard of care required from the doctor and specialist or hospital is no longer that of a hypothetical or fictitious reasonable person.

- (2) What is now required is a more subjective test in which the reasonable doctor or specialist, in the same position as the individual doctor or specialist, set the standard, often referred to as the reasonable expert, be that the reasonable doctor or the reasonable specialist, depending on which branch of the medical field is applicable.¹³²
- (3) Reasonableness in the medical context is defined by our legal writers,¹³³ and the courts alike,¹³⁴ as not the highest possible degree of professional care and skill, but rather, the ordinary or average doctor or specialist endowed with the general level of knowledge, ability, experience, care, skill and diligence possessed by the doctor or specialist in that branch of the medical profession applicable.

6.3.2 ENGLAND

6.3.2.1 Legal Writings

As a general starting point, it must be noted, that in assessing professional negligence in the medical sphere, it is common cause that the standard of skill and care is elevated to the level of the members of the profession and not measured in terms of the reasonable man or

¹³¹ For case law see *Lee v Schönberg* (1877) 7 BUCH 136, *Kovasky v Krige* (1910) 20 CTR 822, *Mitchell v Dixon* 1914 (AD) 519. See also *Coppen v Impey* 1916 CPD 309 at 314; *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) 723-724; *Buls v Tsatsarolakis* 1976 (2) SA 891 (T) 893-894; *Byrne v East London Hospital Board* 1926 EDL 126 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); *R v Van der Merwe* 1953 (2) PH H 124 (W).

¹³² See Boberg *The Law of Delict* (1984) 346; Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 619ff. For case law see *R v Van der Merwe* 1953 (2) PH 4124 (W).

¹³³ Van Oosten *Encyclopaedia* (1996) 82, Gordon Turner and Price *Medical Jurisprudence* (1991) 110; Strauss and McQuoid-Mason *LAWSA* 1983 Vol. 17 Par 151, Dada and McQuoid-Mason *Introduction to Medico-Legal Aspects* (2001) 21-22, Strauss *Doctor Patient and The Law* (1991) 95; Carstens and Pearmain *Principles of South African Medical Law* (2007) 617ff.

¹³⁴ For case law see *Mitchell v Dixon* 1914 (AD) 59 at 525. See also *Coppen v Impey* 1916 CPD 309 at 314; *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) 723-724; *Buls v Tsatsarolakis* 1976 (2) SA 891 (T) 893-894; *Byrne v East London Hospital Board* 1926 EDL 126 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); *Van Wyk v Lewis* 1924 (AD) 438 at 444; *R v Van der Merwe* 1953 (2) PH H 124 (W).

the man on the Clapham omnibus as often referred to by the writers and the courts alike.

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Insofar as the qualified medical practitioner is concerned, broad consensus exist amongst English writers that the qualified medical practitioner will be liable in an action for negligence if he fails to exercise that degree of care and skill which is to be expected of the medical practitioner of the class to which he belongs.¹³⁶

6.3.2.2 Case Law

In what is possibly the leading authority in English case law, McNair J, in the case of *Bolam v Friern Hospital Management Committee*¹³⁷ dealt with the standard of the reasonable professional, including, the doctor, and the specialist. The facts of the case were briefly the following: Mr Bolam was a patient who suffered from depressive illness. His general practitioner referred him to a consultant psychiatrist, who recommended electro-convulsive therapy. There was a school of thought which believed that muscle relaxant drugs should be used during the convulsion, with the intention of preventing the occurrence of fractures. However, the psychiatrist to whom Mr Bolam was referred belonged to a different school of thought, who believed that there were side effects to the use of such drugs and that they outweighed the possible benefits. Mr Bolam duly underwent the treatment without the relaxants, but he, unfortunately, found that both his hips had been fractured in the process. He therefore sued the psychiatrist, together with the anaesthetist, for negligence in terms of failure to use the muscle relaxants.

¹³⁵ See Jackson and Powell (1997) 52; See also Scott (1995) 19. The author in justifying the elevated standard beyond that of the man on the Clapham omnibus states: *"In medical negligence cases, it would be unfair to the defending doctor to impose the expectations too high a standard and it would be correspondently unfair to the plaintiff to expect him to accept a lower standard."* See further Kennedy and Grubb (1998) 336. The authors motivate the elevated standard of the doctor as follows: *"An individual who professes a special skill is indeed, nor by the standard of the man on the Clapham omnibus, but by the standards of his peers. For the 'reasonable man' is substituted the 'reasonable professional'; be it doctor, lawyer, accountant, architect etc."* See further Wright (1993) 30. The author in elevating the standard of care and skill of professional people including the doctor opine that: *"The standard applicable is not the conduct of the reasonable law man but the conduct of the reasonable member of that profession or calling."*

¹³⁶ See Wright (1993) 20. The writer motivates the expectations of the average practitioner in that: *"He will not be judged by the standards of the least qualified member of his class, or by those of the most highly qualified, but by the standards of the ordinarily careful and competent practitioner of that class."* See also Scott (1995) 16. The author opines that generally general practitioners have statutory obligations in terms of the regulations set out in the Family Health Services authority which provide that the general practitioners owes the patient *"a duty to exercise all reasonable skill and care of the kind to be expected of a general practitioner."* *Contra* Kennedy and Grubb (1998) 237 who prefer that the standard ought to be measured against the reasonable competent practitioner with reference to the "hypothetical reasonable doctor".

¹³⁷ 1957 2 ALL ER 118.

McNair J, in what is now widely known as the 'Bolam Test', and subsequently approved by the House of Lords on a number of occasions and what is now regarded as the touchstone of liability for medical negligence, directed the jury as follows:

"But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the Clapham omnibus, because he has not got the special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent, it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art." ¹³⁸

McNair J dismissing the plaintiff's action held:

"A doctor is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art. Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view." ¹³⁹

The test demands that the defendant acts in accordance with accepted practice, which means the practice followed by a responsible body of medical opinion.

In *Hunter v Hanley* ¹⁴⁰ a Scottish judgment referred to in the Bolam case, Lord President Clyde dealt with the question of different professional practices as follows:

"In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of it acting with ordinary care." ¹⁴¹

Where there is more than one common practice, as the Bolam test contemplates, the medical practitioner will be exonerated from liability if he/she shows that he/she followed one of the practices. In *Maynard v West Midlands Regional Health Authority* ¹⁴² Lord

¹³⁸ *Bolam v Friern Hospital Management Committee* (1957) 2 ALL ER 118 121. This case clearly established the precedent that doctors, and indeed other people with special skills, are to be judged against the standards of their colleagues who do the same kind of work.

¹³⁹ *Bolam v Friern Hospital Management Committee* (1957) 2 ALL ER 118.

¹⁴⁰ 1955 SC 200 204-5.

¹⁴¹ *Hunter v Hanley* 1955 SC 200 204-5. The principle enunciated in this case was met with approval in the cases of *Maynard v West Midlands Regional Health Authority* (1984) 1 WLR 534; *Bolam v Friern Hospital Management Committee* (1957) 2 ALL ER 118; *Sidaway v Bethlem Royal Hospital* (1985) AC 871; *Whitehouse v Jordan* (1980) 1 ALL ER 650.

¹⁴² (1984) 1 WLR 634.

Scarman held:

*"It is not enough to show that there is a body of competent professional opinion which considers that theirs was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances. Differences of opinion and practice exist, and will always exist in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgement. A court may prefer one body of opinion to the other; but that is no basis for a conclusion of negligence."*¹⁴³

But Lord Scarman, in the Maynard case, suggested that if uncertainty prevails as to which body of professional opinion to choose from, the 'seal of approval' would fall on a distinguished body of professional opinion, held in good faith, would acquit the defendant of negligence. The approach followed by Scarman in the Maynard case was even more apparent in Lord Scarman's speech in *Sidaway V Bethlem Royal Hospital Governors*¹⁴⁴ where he stated:

*"The Bolam principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care, but the standard of care is a matter of medical judgement."*¹⁴⁵

6.3.2.3 Legal Opinion

- (1) In England, as is the position in South Africa, the standard of care and skill is also elevated beyond the measure of the reasonable man (or the man on the Clapham Omnibus as often referred to by the English writers and the courts alike).¹⁴⁶
- (2) What is also required is more a subjective test, in which the standard of care of the doctor or specialist is measured according to the class to which the doctor and specialist belongs.¹⁴⁷
- (3) But, likewise, the doctor or specialist will not be judged by the standards of the least qualified member of his class nor by those of the most highly qualified. In the

¹⁴³ *Maynard v West Midlands Regional Health Authority* (1984) 1 WLR 634.

¹⁴⁴ (1985) 1 ALL E.R. 643 (A.C.).

¹⁴⁵ *Sidaway v Bethlem Royal Hospital Governors* (1985) 1 ALL E.R. 643 (A.C.).

¹⁴⁶ Jackson and Powell *Professional Negligence* (1997) 52; Scott *The General Practitioner and the Law of Negligence* (1995) 19; Kennedy and Grubb *Principles of Medical Law* (1998) 336; Wright *Medical Malpractice* (1993) 30; for case law see *Bolam v Friern Hospital Management Committee* 1957 2 ALL ER 118 at 121.

¹⁴⁷ Wright *Medical Malpractice* (1993) 20, Scott *The General Practitioner and the Law of Negligence* (1995) 16; Kennedy and Grubb *Principles of Medical Law* (1998) 237. For case law see *Bolam v Friern Hospital Management Committee* 1957 2 ALL ER 118 at 121; *Maynard v West Midlands Regional Health Authority* (1984) 1 WLR. 634, *Sidaway v Bethlem Royal Hospital Governors* (1985) 1 ALL E.R. 643 (AC).

class to which he/she belongs, what is expected of him/her is the standard of ordinarily careful and competent medical practitioners of that class.¹⁴⁸

6.3.3 UNITED STATES OF AMERICA

6.3.3.1 Legal Writings

In measuring the doctor's standard of care, the core opinion in legal writings in the United States of America is that a physician is not considered, by the law, to be holding himself out as the most highly qualified of physicians. Nor does a physician in accepting a patient tacitly declare that he possesses the highest level of skill.¹⁴⁹

What is expected of him/her as a physician, however, is to employ such reasonable skill and care as are commonly exercised by advanced physicians in the same general school of practice and in the same locality or in localities substantially similar to it.¹⁵⁰

¹⁴⁸ Wright *Medical Malpractice* (1993) 20. For case law see *Hunter v Hanley* 1955 SC 200 at 204-205. The principle enunciated in this case was the approval in the cases of *Maynard v West Midlands Regional Health Authority* (1984) 1 WLR 534; *Bolam v Friern Hospital Management Committee* (1957) 2 ALL ER 118; *Sidaway v Bethlem Royal Hospital* (1985) AC 871; *Whitehouse v Jordan* (1980) 1 ALL ER 650.

¹⁴⁹ See Waltz and Inbau (1971) 45; See also Furrow et al (1995) 237. The authors state that: "A physician is not required to exercise the highest degree of care possible." What is required of the physician is that he holds himself out as "a reasonable physician under similar circumstances." See *American College of Legal Medicine* (1991) 43. See also Southwick and Slee (1988) 52. The authors describe the standard of care as "... reasonable and ordinary care, skill and diligence as physicians and surgeons in good standing in the same neighbourhood, in the general line of practice, ordinarily exercised in like uses." The writers Hill and McMenemy in "Contracts, Agency, and Partnership" a chapter published in *American College of Legal Medicine* (1991) 62 in acknowledging the fiduciary relationship between physician and patient based on contract holds the view that in accepting the patient "the physician impliedly promises the patient that he or she will exercise that degree of skill ordinarily possessed by his or her colleagues and practice according to accepted standards." See also Peters et al (1981) 155-156; See also Moore and Kramer (1990) 6-7; See further Holder (1975) 3. The author states that in the absence of any other undertaking by the physician the courts usually hold that the physician made "that he has the normal degree of skill, care and knowledge and that he will use all three in treating the patient." Holder (1975) at 43 formulates the standard against which conduct a physician who allegedly transgressed its reasons namely: "The reasonably prudent physician or surgeon, acting under the same circumstances." See also Peter et al (1981) 153. The standard set to be achieved is formulated by Shea and Sidley (1985) 95ff: "... nor is he required to exercise extraordinary skill and care, nor even the highest degree of skill and care possible. (Not all persons can be extraordinary in their ability to perform their profession). The law requires only what is reasonable under the circumstances." See also Potgar et al (1996) 47.

¹⁵⁰ The application of the so-called 'locality rule' which has as a result the localization of the standard of care and skill to a geographical area is widely recognised by the American legal writers. See *American College of Legal Medicine* (1991) 132-133. See further Holder (1975) 53. The author holds the view that the ratio behind establishing the rule stem from the fact that: "... physicians practicing in isolated rural areas, for example, should not be expected to be as well trained and up-to-date as a physician in an urban environment." Southwick and Slee (1988) 56 also recognize that in certain cases physicians would not be responsible for providing certain care "if the necessary facilities or resources were not available." *contra* Waltz and Inbau (1971) 64. The writers hold the view that the traditional 'locality rule' is losing ground in the modern era in that "the education and training which he has received in institutions in which the method and scope of instruction and the technique in training are substantially uniform." The writers are also of the opinion that the very reason for introducing the 'locality rule' was founded in communications being slow or non-existent has in modern times changed in that: "... it has lost much of its significance today with the increasing number and excellence of medical schools, the free inter change of scientific

What emerges from the fore stated) is that by accepting a patient, the physician or surgeon impliedly represents that he has the necessary training, knowledge, and skill and that he will employ these attributes in the way any reputable physician ordinarily would. But it does not entail that the physician or surgeon guarantees total success whenever treatment is undertaken.¹⁵¹

In the absence of an express contractual promise, the physician is not, however, considered a guarantor of good results.¹⁵²

6.3.3.2 Case Law

The first reported American malpractice action decided upon by a court in Connecticut, America was that of *Cross v Guthery*.¹⁵³ The plaintiff averred that his wife died from a mastectomy performed in a negligent manner by the physician. The court found for the Plaintiff and held that the physician performed the operation in the most unskilful, ignorant and cruel manner, contrary to all well-known rules and principles of practice in such cases.¹⁵⁴ Although the court does not motivate what is deemed to be "well-known principles of practice", it can safely be assumed that, in finding in favour of the plaintiff, the court, by implication, found that the physician deviated from the acceptable standard of care at the time of the operation and in so doing, he failed to exercise reasonable care and skill. Instead the operation was carried out in a cruel manner causing a lot of pain.

The case which is regarded as the *locus classicus* in American Case Law concerning the

information, and the consequent tendency to harmonize medicine standards throughout the country." See also Furrow et al (1995) 238 who opine that most jurisdictions have moved from the 'locality rule' to a natural standard for specialists. However the standard of practice for general practitioners will still be based on the local community or a similar community. See also Peters et al (1981) 155-157; See further Southwick and Slee (1988) 56.

¹⁵¹ See Waltz and Inbau (1971) 46. The authors opine that: "*The working of miracles is no more expected of the medical profession than of any other calling.*" See also Alton (1977) 24 who warns physicians against the consequences of guaranteeing a result or a cure in that "*if an unavoidable complication occurs, preventing the anticipated result, the physician has still breached his obligation and are liable.*" See also Southwick and Slee (1988) 42.

¹⁵² See Furrow et al (1995) 237. The authors state that: "*A physician is not a guarantor of good results.*" See also *American College of Legal Medicine* (1991) 63 122-123 208. The authors state that: "*Without a specific warranty, courts will not infer that a physician guaranteed the success of treatment.*" See also Holder (1975) 3. The author opines that: "*Where however, a physician does guarantee results, and the results are not obtained, he is liable for breach of warranty even if he has used the highest skill.*"

¹⁵³ *Cross v Guthery* 2 Root 90 (C Court 1794).

¹⁵⁴ *Cross v Guthery supra* 91.

duty of care of a physician towards his/her patient and the standard of care required is that of *Pike v Honsinger*.¹⁵⁵ The facts of this case can briefly be sketched as follows: "The patient had been kicked in the knee by a horse and claimed that the defendant had set it in a negligent manner, resulting in a failure of the bones to unite. The court said:

*"The law relating to malpractice is simply and well settled, although not always easy of application. A physician and surgeon, by taking charge of a case, impliedly represents that he possesses, and the law places upon him the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons in the locality in which he practices, and which is ordinarily regarded by those conversant with the employment as is necessary to qualify him to engage in the business of practising medicine and surgery. Upon consenting to treat a patient, it becomes his duty to use reasonable care and diligence in the exercise of his skill and the application of his learning to accomplish the purpose for which he was employed. He is under the further obligation to use his best judgement in exercising his skill and applying his knowledge. The law holds him liable for an injury to his patient resulting from want of the requisite skill and knowledge or the omission to exercise reasonable care or the failure to use his best judgement. The rule in relation to learning and skill does not require the surgeon to possess that extraordinary learning and skill which belong only to a few men of rare endowments, but such as is possessed by the average member of the medical profession in good standing. The rule of reasonable care and diligence does not require the use of the highest possible degree of care and to render a physician and surgeon liable, it is not enough that there has been a less degree of care than some other medical man might have shown or less than even he himself might have bestowed, but there must be a want of ordinary and reasonable care, leading to a bad result."*¹⁵⁶

The Pike judgement is of great importance in that, the principle enunciated in this case, set a standard of care which includes, firstly, that the physician possesses a reasonable degree of learning and skill which he will apply with reasonable care and diligence, and secondly, the physician is not expected to possess extraordinary learning and skill, but, rather as is possessed by the average member of the medical profession in good standing. Therefore, what is expected of the physician is reasonable care and skill.

The Supreme Court of Indiana broadens this definition in 1938 in the case of *Adkins v Ropp*.¹⁵⁷ This case involved a patient who had lost the sight of one eye. He claimed that the defendant had been negligent in removing a foreign body from it and the eye had then become infected as the result of the negligence. The defendant argued that the infection was an unavoidable result of the original injury. That court said:

"When a physician and surgeon assumes to treat and care for a patient, in the absence of a special agreement, he is held in law to have impliedly contracted that he possesses the reasonable and ordinary qualifications of his profession and that he will exercise at least reasonable skill, care and diligence in his treatment of him. This implied contract on the part of the physician does not include a promise to effect a cure and negligence cannot be imputed because a cure is not effected, but he does impliedly promise that he will use due diligence and ordinary skill in his treatment of the patient so that a cure may follow such care and skill, and this degree of care and skill is required of him, not only in performing an operation or administering first treatments, but he is held to the like degree of care

¹⁵⁵ 49 NE 760 New York (1898).

¹⁵⁶ *Pike v Honsinger* 49 NE 760, NY. 1898.

¹⁵⁷ 14 NE 2d 727, Ind. 1938.

and skill in the necessary subsequent treatments unless he is excused from further service by the patient himself, or the physician or surgeon upon due notice refuses to further treat the case. In determining whether the physician or surgeon has exercised the degree of skill and care which the law requires, regard must be had to the advanced state of the profession at the time of treatment and in the locality in which the physician or surgeon practices."

The Adkins case expanded on the Pike judgement in that a physician is not expected to guarantee a cure. Therefore, a physician will not incur liability if an adverse and unforeseeable result ensues for as long as the physician exercised due care and skill.

The physician will incur liability if he does not supply subsequent treatment unless he is excused from further service by the patient himself, or the physician or surgeon upon due notice, refuses to further treat the case.

The fore stated conduct, is measured against that of the average reasonable physician or Surgeon, in the locality in which he practices, and, at the state of advance of the profession at the time of treatment.

6.3.3.3 Legal Opinion

- (1) The degree of care and skill expected of a physician and a specialist, as is the position in England and South Africa, is also elevated beyond that of a reasonable person.¹⁵⁸
- (2) The standard of care is also measured in terms of a subjective test in which the standard of the physician or specialist in question is measured against the degree of care and skill ordinarily possessed by his or her colleagues and practice according to accepted standards (referred to often as the ordinary care, skill and diligence as physicians and surgeons in good standing in the same neighbourhood, in the general line of practice).¹⁵⁹
- (3) The physician or surgeon is also not judged by the highest degree of care and skill nor the lowest on the grid, but rather, on what is reasonable under the

¹⁵⁸ See Waltz and Inbau *Medical Jurisprudence* (1971) 45, Furrow et al *Health Law* (1995) 237; Southwick and Slee *The Law of Hospital and Healthcare Administration* (1988) 52, Hill and McMenamin "Contracts, Agency and Partnership" A Chapter published in the *American College of Legal Medicine* (1991).

¹⁵⁹ See Waltz and Inbau *Medical Jurisprudence* (1971) 45, Furrow et al *Health Law* (1995) 237; Southwick and Slee *The Law of Hospital and Healthcare Administration* (1988) 52, Hill and McMenamin "Contracts, Agency and Partnership" A Chapter published in the *American College of Legal Medicine* (1991); Peters et al *The Law of Medical Practise in Michigan* (1981) 155-156; Moore and Kramer *Medical Malpractice: Discovery and Trial* (1990) 6-7, Holder *Medical Malpractice Law* (1975) 3, 43, Shea and Sidley *Law and Ethics* (1985) 195ff, Potgar et al *Legal Aspects of Healthcare Administration* (1996) 47. For American case law see the leading case of *Pike v Honsinger* 49 NE 760 New York (1898); *Adkins v Ropp* 14 NE 2d 727 Ind. 1938.

circumstances.¹⁶⁰

6.4 THE ELEVATED STANDARD OF CARE OF THE MEDICAL SPECIALIST

6.4.1 SOUTH AFRICA

6.4.1.1 Legal Writings

It is generally the opinion amongst our legal writers that the experience, knowledge and the degree of care and skill required from a general medical practitioner to assess whether his or her conduct constitutes negligence, is not the same as that required from a medical specialist.¹⁶¹

Of the specialist is expected a greater degree of skill than that of a general practitioner.¹⁶²

But, notwithstanding this greater expectation required from the specialist, his or her conduct nevertheless, is measured against the average or reasonable specialist attached to the branch of the profession to which he or she belongs.¹⁶³

6.4.1.2 Case Law

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, a greater degree of skill is expected than that of a general practitioner.¹⁶⁴

¹⁶⁰ See Waltz and Inbau *Medical Jurisprudence* (1971) 45, Furrow et al *Health Law* (1995) 237; Southwick and Slee *The Law of Hospital and Healthcare Administration* (1988) 52, Hill and McMenamin "Contracts, Agency and Partnership" A Chapter published in the *American College of Legal Medicine* (1991); Peters et al *The Law of Medical Practise in Michigan* (1981) 155-156; Moore and Kramer *Medical Malpractice: Discovery and Trial* (1990) 6-7, Holder *Medical Malpractice Law* (1975) 3, 43, Shea and Sidley *Law and Ethics* (1985) 195ff, Potgar et al *Legal Aspects of Healthcare Administration* (1996) 47. For American case law see the leading case of *Pike v Honsinger* 49 NE 760 New York (1898); *Adkins v Ropp* 14 NE 2d 727 Ind. 1938.

¹⁶¹ See Van Oosten (1986) 19; See also Van Oosten (1996) 83; Carstens 1996 Unpublished LLD Thesis (1996) 157; Carstens and Pearmain (2007) 623ff.

¹⁶² See Gordon Turner and Price (1953) 113. The writers argue the ratio behind such greater expectancy arises from the fact that "a specialist by definition holds himself out as possessing greater skill in his speciality than can reasonably be expected from the doctor, whose practise covers a much wider field." The writers add "the specialist should be particularly skilled in the speciality". See also Strauss and Strydom (1967) 268; Neethling Visser and Potgieter (1996) 134; Van der Walt (1974) 69; Dada and McQuiod-Mason (2001) 22; McQuiod-Mason and Strauss (1983) 151; Carstens (1996) 137; Carstens and Pearmain (2007) 623ff.

¹⁶³ See Gordon Turner and Price (1953) 113. The author caution that the skill required of the specialist is "that of an average specialist, not that of an exceptionally able or gifted one." See also Strauss and Strydom (1967) 124. The authors share the view "the yardstick for measuring the conduct of the specialist should be the branch of the profession to which the specialist belongs." Carstens and Pearmain (2007) 623.

¹⁶⁴ *Van Wyk v Lewis* (1924) (AD) 438 at 457.

His or her standard of conduct is elevated to the reasonable expert standard. The distinction in the expected conduct of a specialist, as opposed to that of a general practitioner, is stated as follows by Roper J in the case of *R v Van der Merwe*.¹⁶⁵

*"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 do not follow that you must expect the general practitioner to act in the same way. But the question needs to be begged what is the common knowledge in the branch of the profession to which the accused belongs? What is the common knowledge and accepted practice among the general practitioners? When the specialists 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."*¹⁶⁶

As a consequence thereof, he or she will be judged with the reasonable expert standard and may, very well, incur liability for negligence, being ascribed to his or her want of knowledge, experience, skill and diligence.¹⁶⁷

What is, however, of further 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.¹⁶⁸ A greater standard of care and skill is also expected of a practitioner and/or nursing staff where more complicated medical procedures are executed.¹⁶⁹

¹⁶⁵ 1953 (2) PH H 124 (W). This dictum was endorsed by Bekker J in *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T) at 723 - 724; The distinction in the standard of care expected from a specialist, as a reasonable expert, as opposed to that of the general practitioner, is also recognised in *Buls v Tsatsarolakis* 1996 (2) SA 891 (T) 893 - 894; *S v Kruger* (1976) (3) SA 290 (O); *S v Mkwetshana* (1965) (2) SA 493 (N) at 496; *Pringle v Administrator, Transvaal* (1990) (2) SA 379 (W) at 384.

¹⁶⁶ *R v Van der Merwe* 1953 (2) PH 11 124 (W).

¹⁶⁷ The position is described as follows in the case of *Coppen v Impey* 1916 CPD 314 in which Kotze J stated: *"Before doing so it will be advisable to state succinctly the law applicable to the responsibility of a medical man in the treatment of his patient. While, on the one hand, 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 unskilfulness in his treatment; for holding himself out as a professional man, he undertakes to perform the service required of him with reasonable skill and ability. Unskilfulness, on his part is equivalent to negligence and renders him liable to a plaintiff, who has sustained injury there from, the maxim of the law being imperitia culpa adnumeratur."* See also *Byrne v East London Hospital Board* 1926 EDL 138, 143, 153, 158; *R v Van Schoor* 1948 (4) SA 349 (C) at 351 - 352. In the case of *S v Mkwetshana* 1965 (2) 493 the court summarizes the position as follows: *"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 inexperience, and particular his inexperience of the drug and its uses, marks him as being negligent."*

¹⁶⁸ See *Van Wyk v Lewis* (1924) (AD) 438 at 444; *R v Van der Merwe* 1953 (2) PHH 103; *Esterhuizen v Administrator, Transvaal* 1957 (3) 710 T at 723 - 724; *Buls v Tsatsarolakis* 1976 (2) SA 891 (T) at 893 - 894; *S v Mkwetshana* (1965) (2) 493 (N) at 496.

¹⁶⁹ See *Collins v Administrator Cape* 1995 (4) SA (CPD) 73 at 82. In this case Scott J emphasized *"the need for particular care and vigilance in the case of the paediatric tracheotomy patient."* But cautioned the court *"but a standard of excellence cannot be expected which is beyond the financial resources of the hospital authority."*

6.4.1.3 Legal Opinion

- (1) In South African Law a clear distinction is made between the experience level, level of knowledge and the degree of care and skill required from a general medical practitioner as opposed to the specialist.¹⁷⁰
- (2) Of the specialist is expected a greater degree of skill than that of the general medical practitioner.¹⁷¹
- (3) Nonetheless, the conduct of the specialist is measured against the average or reasonable specialist attached to the branch of the profession to which he or she belongs.¹⁷²

6.4.2 ENGLAND

6.4.2.1 Legal Writings

The English writers share the view that when a medical man holds himself out as being a specialist in a particular field, whether it is in the treatment of certain conditions or in the use of certain apparatus or in any other way, he/she will necessarily be judged by higher standards than the ordinary practitioner, who does not profess any such specialized skill.¹⁷³

¹⁷⁰ Van Oosten "Professional Negligence in South African Legal Practise" (1986) *Medicine and Law* 19; Van Oosten *Encyclopaedia* (1996) 83; Carstens "Die Straftelike en Deliktuele Aanspreeklikheid van die Geneesheer op Grond van Nalatigheid" (An Unpublished Thesis - LLD) (1996) 137ff. See also *Van Wyk v Lewis* (1924) (AD) 438 at 457; *R v Van der Merwe* 1953 (2) PH H 124 (W); *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) 723-724; *Buls v Tsatsarolakis* 1996 (2) SA 891 (T) 893-894; *S v Kruger* 1976 (3) SA 290 (O); *S v Mkwetshana* 1965 (2) SA 493 (N); *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W) at 384; Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 623.

¹⁷¹ Gordon Turner and Price *Medical Jurisprudence* (1953) 113; Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 268; Neethling et al *Deliktereg* (1996) 134; Van der Walt *Delict: Principles and Cases* (1979) 69; Dada and McQuoid-Mason *Introduction to Medico-Legal Aspects* (2001) 22; McQuoid-Mason and Strauss *Lawsa* Vol 17 (1983) Par 151; Carstens "Die Straftelike en Deliktuele Aanspreeklikheid van die Geneesheer op Grond van Nalatigheid" (An unpublished thesis - LLD) (1996) 137. See also *Van Wyk v Lewis* (1924) (AD) 438 at 457; *R v Van der Merwe* 1953 (2) PH H 124 (W); *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) 723-724; *Buls v Tsatsarolakis* 1996 (2) SA 891 (T) 893-894; *S v Kruger* 1976 (2) SA 290 (O); *S v Mkwetshana* 1965 (2) SA 493 (N); *Pringle v Administrator Transvaal* 1990 (2) SA 379 (W) at 384; Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 623.

¹⁷² *Van Wyk v Lewis* (1924) (AD) 438 at 444; *R v Van der Merwe* 153 (2) PH H 103; *Esterhuizen v Administrator, Transvaal* 1957 (3) 710 (T) at 723-724; *Buls v Tsatsarolakis* 1976 (2) SA 891 (T) at 893-894; *S v Mkwetshana* 1965 (2) SA 493 (N) at 496.

¹⁷³ See Wright (1993) 22. The writer also emphasizes that: "... here again the specialist will be required to attain not to the very highest degree of skill and competence but to the ordinary level obtaining amongst those who specialise in the same subject." See also Scott (1995) 33 who clearly distinguishes between the elevated standard of the specialist as opposed to the general practitioner in that "a higher standard" is expected from a surgeon. The author opines that the Bolam decision was referring "to specialism" in that "the doctors concluded in that cases were psychiatrists and anaesthetists, and their treatment would have to be compared with that of the other doctors in that particular speciality." See further Kennedy and Grubb (1998) 358. The authors opine that a

Where a medical practitioner generally does not possess the relevant qualifications, expertise or skill but he/she nevertheless undertakes the treatment of a patient, he/she will come under the same duty of care, since, by undertaking the treatment, he/she effectively represents that he/she does possess the skills.¹⁷⁴

Where a general practitioner engages in activities which required the knowledge and skill of a specialist, whilst he/she does not possess the required attributes, resulting in the Patient, suffering damages, he/she would be negligent and held liable.¹⁷⁵

6.4.2.2 Case Law

English courts have consistently held that the standard of conduct expected from a general practitioner differs from that of a specialist.

In the case of *Sidaway v Governors of Bethlem Royal Hospital*¹⁷⁶ the court recognized the elevated standard of conduct of the specialist when the court by way of Lord Bridge stated:

"The language of the Bolam test clearly requires a different degree of skill from a specialist in his field than from a general practitioner. In the field of neuro-surgery it would be necessary to substitute for the Lord President's phrase 'no doctor of ordinary skill', to phrase 'no neuro-surgeon of ordinary skill'. All this is elementary and, in

specialist is required "... to achieve the standard of care of a reasonably competent specialist in his field, exercising 'the ordinary skill of his speciality'." The authors also caution: *"The standard of care within a specialist field is that of the ordinary competent specialist, not the most experienced or most highly qualified within the specialty."*

¹⁷⁴ See Jones (1996) 34-35. The writer takes the view that in such event "the duty derives from the fact that he/she holds himself/herself out as someone competent and undertakes legal responsibility to that extent." See also Wright (1993) 20 who opines that: *"..... where a person represents that he is possessed of special skill or knowledge in the conduct of a profession or calling, the law demands of him that he in fact possesses that skill and knowledge, and the very fact that a man carries on a profession or calling, the practice of which requires special skill or knowledge, constitutes a representation on his part that he possesses the requisite qualifications."*

¹⁷⁵ See Winfield and Jolowicz on Tort (1994) 88. The authors in recognizing the Roman law doctrine of *imperitia culpa adnumeratur* states: *"The rule imperitia culpa adnumeratur is just as true in English law as in Roman law. The rule must however be applied with some care to see that too high a degree of skill is not demanded. A passerby who renders emergency first-aid after an accident is not required to show the skill of a qualified surgeon. It is notable that in most professions and trades each generation convicts its predecessor of ignorance and there is a steady rise in the standard of competence incident to them. The surgeon must exercise such care as accords with the standards of reasonably competent medical men at the time but he is not an insurer against every medical slip. He must keep himself reasonably up to date and cannot obstinately and pig-headedly carry on with the same old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion."* See also Percy Charlesworth (1977) 970 who holds the view that: *"The competent practitioner will know when a case is beyond his skill, and thereupon it becomes his duty either to call in a more skilful person or to order the removal of the patient to a hospital where skilled treatment is available."* See further Jackson and Powell (1997) 296; Martin (1979) 360.

¹⁷⁶ (1985) 1 ALL ER 643 (A.C.).

light of the two recent decisions of this House, firmly established law." ¹⁷⁷

The separate distinction in the standard of care between the doctor and specialist is recognized in the case of *Landu v Werner* ¹⁷⁸ in which Sellers LJ held:

"A doctor's duty is to exercise ordinary skill and care according to the ordinary and reasonable standards of those who practise in the same field of medicine. The standard for the specialist is the standard of the specialists. A doctor is not negligent if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in the particular act." ¹⁷⁹

The interpretation of the Bolam test as per Lord Scarman was not agreed on by Lord Bridge in the *Sidaway* ¹⁸⁰ decision when he said:

".... The issue whether non-disclosure in a particular case should be condemned as a breach of the doctor's duty of care is an issue to be decided primarily on the basis of expert medical evidence, applying the Bolam test. Of course, if there is a conflict of evidence whether a responsible body of medical opinion approves of non-disclosure in a particular case, the judge will have to resolve that conflict. But, even in a case where, as here, no expert witness in the relevant medical field condemns the non-disclosure as being in conflict with accepted and responsible medical practice, I am of opinion that the judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it." ¹⁸¹

In the case of *Whitehouse v Jordan* ¹⁸² the court was confronted with the question of whether a specialist should be completely exculpated after the delivery of a baby caused severe damages. The facts are to be stated briefly as follows: The defendant was in charge of the plaintiff's delivery. The plaintiff, Stuart Whitehouse, was born with severe and

¹⁷⁷ *Sidaway v Bethlem Royal Hospital Governors* (1985) 1 ALL E.R. 643 (A.C.).

¹⁷⁸ (1961) 105 SJ 1008.

¹⁷⁹ *Landu v Werner* (1961) 105 SJ 1008.

¹⁸⁰ (1985) 1 ALL ER 643 662-3.

¹⁸¹ See *Sidaway v Bethlem Royal Hospital Governors* (1985) 1 ALL ER 643 662-3. See also the comments of Sir John Donaldson MR in the Court of Appeal (1984) 1 ALL ER 1018, 1028 in the *Sidaway* case on appeal when he stated: *"The definition of the duty of care is a matter for the law and the courts. They cannot stand idly by if the profession, by an excess of paternalism, denies its patients a real choice. In a word, the law will not permit the medical profession to play God."* He goes on to state: *"In an appropriate case a judge would be entitled to reject a unanimous medical view if he were satisfied it was manifestly wrong and that the doctors must have been misdirected themselves as to their duty in law. Thus a practice must be 'rightly' accepted as proper by the profession."* The second approach by Lord Bridge and Sir John Donaldson appear to be the correct approach in that a more objective judgement would ensure less partisan of the medical profession. This view is preferred by Kennedy and Grubb (1998) 341-2 who express the opinion that "a court may condemn every universally followed practice concerning risk disclosure as negligent on the basis that the hypothetical reasonable doctor would not have adopted it. There is no reason to confine this approach to risk disclosure since the majority of their Lordship in *Sidaway* said that the Bolam test applied to all aspects of the doctor's duty of care diagnosis, advice and treatment."

¹⁸² (1981) 1 ALL E.R. 265 (1981) 1 W.L.R. 246.

irreparable brain damage, following a high risk pregnancy. After Stuart's mother had been in labour for 22 hours, the defendant decided to carry out a test to see whether forceps could be used to assist the delivery. He made six attempts to deliver the baby with the forceps before quickly and competently proceeding to a caesarean section. Acting through his mother, as next friend, the plaintiff claimed damages for negligence alleging (i) that the defendant had been negligent in pulling too long and too hard with the forceps - the six attempts with the forceps had taken some 25 minutes - and (ii) that in doing so he had caused the brain damage.

Lord Edwin D-Davies applying the Bolam test held that:

"Where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. If a surgeon fails to measure up to that standard in any respect (clinical judgement or otherwise), he has been negligent and should be so adjudged." ¹⁸³

Lord Fraser in particular in assessing the standard of conduct expected of a specialist stated:

"A failure to exercise the standard of skill expected from the ordinary competent specialist having regard to the experience and expertise that specialist holds himself out as possessing." ¹⁸⁴

English case law recognizes the Roman law doctrine *imperitia culpa adnumeratur* in that a qualified person may be held liable for undertaking a case for which he knew, or should have known, he did not have the required expertise.

In the case of *R v Bateman* ¹⁸⁵ Lord Hewat CJ stated:

"It is no doubt, conceivable that a qualified man may be held liable for recklessly undertaking a case which he knew, or should have known, to be beyond his powers." ¹⁸⁶

In the case judgement Lord Hewat CJ held:

"The unqualified practitioner cannot claim to be measured by any lower standard than that which is applied to a

¹⁸³ *Whitehouse v Jordan* (1981) 1 ALL E.R. 264 (1981) 1 W.L.R. 246.

¹⁸⁴ *Whitehouse v Jordan* (1981) 1 ALL E.R. 267 (1981) 1 W.L.R. 246.

¹⁸⁵ (1925) 94 L.J.K.B 791, 791.

¹⁸⁶ *R v Bateman* (1925) L.J.K.B. 791, 791.

qualified man." ¹⁸⁷

6.4.2.3 Legal Opinion

- (1) In England, the conduct of a general medical practitioner in medical negligence cases is adjudged differently from that of a specialist. ¹⁸⁸
- (2) The specialist will be judged by a higher standard than that of the general medical practitioner, as it is generally accepted that the general medical practitioner does not possess the same qualification, expertise or specialized skill as that of the specialist. ¹⁸⁹
- (3) The standard of conduct of the specialist is, nevertheless, measured by expected conduct or practice of the ordinary competent specialist without expecting too high a standard of care and skill. ¹⁹⁰

6.4.3 UNITED STATES OF AMERICA

6.4.3.1 Legal Writings

The acceptable levels of training, knowledge and skill required, by law, of a specialist are not the same as that of a physician. ¹⁹¹ It has generally been accepted, by the legal writers

¹⁸⁷ *R v Bateman* (1925) L.J.K.B. 791, 794; See also *Pippen v Shephard* 1822 ER. 400, 409; *Jones v Fay* (1865) 4f AL F 5 25; See further *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582; *Chin Keow v Government of Malaysia* supra 813; *Roe v Ministry of Health* (1954) 2 OB 6.

¹⁸⁸ Wright *Medical Malpractice* (1993) 22; Scott *The General Practitioner and the Law of Negligence* (1995) 33; Kennedy and Grubb *Principles of Medical Law* (1998) 358. For case law see *Sidaway v Governors of Bethlem Royal Hospital* (1985) 1 ALL ER 643 (A.C.); *Landu v Werner* (1961) 105 SJ 1008; *Whitehouse v Jordan* (1981) 1 ALL. E.R. 265 (1981) 1. W.C.R. 246.

¹⁸⁹ Wright *Medical Malpractice* (1993) 22; Scott *The General Practitioner and the Law of Negligence* (1995) 33; Kennedy and Grubb *Principles of Medical Law* (1998) 358. For case law see *Sidaway v Governors of Bethlem Royal Hospital* (1985) 1 ALL ER 643 (A.C.); *Landu v Werner* (1961) 105 SJ 1008; *Whitehouse v Jordan* (1981) 1 ALL. E.R. 265 (1981) 1. W.L.R. 246.

¹⁹⁰ Wright *Medical Malpractice* (1993) 22; Kennedy and Grubb *Principles of Medical Law* (1998) 358. *Landu v Werner* (1961) 105 SJ 1008; *Whitehouse v Jordan* (1981) 1 ALL. E.R. 265 (1981) 1. W.L.R. 246.

¹⁹¹ See Kramer and Kramer (1983) 5 quoting from the *Corpus Juris Secundum*: "A physician holding himself out as having special knowledge and skill in the treatment of a particular organ, disease or type of injury is bound to bring to the discharge of his duty to a patient employing him as such specialist, not merely the average degree of skill possessed by general practitioners, but that special degree of skill and knowledge possessed by physicians who devote special study and attention to the treatment of such organ disease or injury, regard being had to the state of scientific knowledge at the time." Commenting thereon the authors opine: "When the doctor is a specialist, he is bound to exercise the degree of skill and knowledge that is ordinarily possessed by similar specialists, and not merely the degree of skill and knowledge of a general practitioner." See also Holder (1975) 55. The author expresses the standard of care a specialist has to adhere to as that of the "reasonably careful and prudent specialist in his field" as opposed to "the reasonably careful and prudent physician." See also McCoid "The Care required of Medical Practitioners" 1959 *Van der Bit. Law Review* 549. The writer draws the distinction of the

in America, that the standard and degree of care and skill, expected judicially, of the specialist is higher than that expected of a general reasonable practitioner.¹⁹²

Where a general practitioner gives himself/herself out as a specialist, or where a general practitioner fails to refer a patient to a specialist in circumstances which warrant such referral, and at the same time he or she knows that he/she does not possess the required care and skill of a specialist required in the circumstances to treat the patient, his/her conduct may be regarded as negligent. In such event, the conduct of the general practitioner/physician will be measured against that of the reasonable specialist and not the general reasonable physician.¹⁹³

6.4.3.2 Case Law

standard expected from a specialist as opposing to the physician as follows: *"A physician who holds himself out as having special knowledge and skill in the treatment of a particular organ or disease or injury is required to bring to the discharge of his duty to the patient employing him as such specialist not merely the average degree of skill possessed by general practitioners but that special degree of skill and care which physicians similarly situated who devote study and attention to the treatment of such organ disease, or injury ordinarily possess, regard being had to the state of scientific knowledge at the time."* See further Peters et al (1981) 156; See further Southwick and Slee (1988) 58.

¹⁹² The physician's legal duty is stated in a generalized way by the legal writers as employing such reasonable skill and care exercised by the average physician. See in this regard Waltz and Inbau (1971) 42 45; See also Furrow et al (1995) 237; See further Morris and Moritz (1971) 135; *American College of Legal Medicine* (1991) 43 62-63; The duty of the physician is described by the College of *Legal Medicine* (1991) 119 as: *"This duty requires that a physician possess and bring to bear on the patient's behalf that degree of knowledge, skill, and care usually exercised by a reasonable and prudent physician under similar circumstances, given the prevailing state of medical knowledge and available resources. In other words, physicians owe their patients a duty to act in accordance with the specific norms or standards established by their profession, commonly referred to as "standards of care" to protect their patients against unreasonable risk."* See further Holder (1975) 3 and at 43 who describes the duty of the physician as: *"The physician must have adequate knowledge and skill and use it with adequate care in his dealings with a patient. The reasonably prudent physician or surgeon, acting under the same circumstances is the standard by which his conduct will be judged."* See further Kramer and Kramer (1983) 6 11; Sidley and Shea (1985) 183-184.

¹⁹³ See Rheingold and Davey *Standard of Care in Medical Malpractice Cases* (1975) (Red Conason) 16. The author states: *"Within the field of medicine there are numerous specialties. The specialist is to be judged by the higher standard of care, skill and knowledge possessed and used by like specialists, and not those of the 'average' physician who might be a general practitioner. The specialist is expected to know more and to be able to do more within his speciality. One who holds himself out as a specialist is to be held to that specialist's care, just as one who holds himself out generally to be a licensed practitioner must come up to the standard pretended to."* See also Holder (1975) 55. The author states that: *"The standard to which a specialist must adhere to is quite a bit broader than that which the courts consider reasonable to expect from a non-specialist."* See further Waltz and Inbau (1971) 44. The authors hold the view that referrals to specialists in modern day are necessary as the general practitioner despite his good intentions may be ill-equipped to treat the patient due to the fact that: *"The general practitioner today cannot keep up with all the latest developments in every phase of medicine and surgery."* If he does treat the patient and not refer the patient to the specialist as indicated *"he does so at his peril."* But the physician's adoption of speciality does not ease the standard of care governing his or her standard of conduct. Quite the contrary, the authors advocate in that: *"If a practitioner holds himself out as a specialist, he will undoubtedly be held to a higher degree of skill and knowledge than a general practitioner."* See further Holder (1975) 43 47; Moore and Kramer (1990) 7; Southwick and Slee (1988) 57-58.

There are a number of cases in which the American courts have clearly distinguished between the standard and degree of care and skill expected of a specialist, as opposed to a general practitioner, in which it was held that a higher standard and degree of care and skill is expected of the specialist. The general principle in this regard was enunciated in the case of *Belk v Schweizer*¹⁹⁴ in which the court held:

*"A physician who holds himself out as having special knowledge and skill in the treatment of a particular organ or disease or injury is required to bring to the discharge of his duty to the patient employing him as such specialist not merely the average degree of skill possessed by general practitioners but that special degree of skill and care which physicians similarly situated who devote study and attention to the treatment of such organ disease, or injury ordinarily possess, regard being had to the state of scientific knowledge at the time."*¹⁹⁵

The broader standard of knowledge and skill of a specialist is also recognized in the case of *Bullock County Hospital Association v Fowler*.¹⁹⁶ The facts concerned a resident in obstetrics and gynaecology who was allegedly negligent in performing a circumcision. In the course of the trial, he testified that he had performed between 600 and 800 circumcisions prior to the one which was involved in the suit. The court, therefore, held that he would be considered a specialist even though he had not completed his training. In comparing the standard required of a specialist with that of a general practitioner, the court stated: *"It would not seem at all unreasonable to hold him to a higher standard of care than that required of a general practitioner, although he has only completed one-third of his residency. The difference between the duty owed by a specialist and that owed by a general practitioner lies not in the degree of care required but in the amount of skill required. It would stand to reason that one who had performed between 600 and 800 circumcisions would, and should, be expected to have more skill in performing such operations than would a general practitioner."*¹⁹⁷

It has also been decided, in American Law, that a general practitioner who undertakes to treat a case that clearly lies within the field of a special branch of medicine, will be held liable for failure to use skill equal to that of a specialist.

In the case of *Monahan v De Vinny*¹⁹⁸ the facts can be stated briefly as follows:

¹⁹⁴ 149 SE 2d 565, NO 1966.

¹⁹⁵ *Belk v Schweizer* 149 SE 2d 515, NO 1966.

¹⁹⁶ 183 SE 2d 586, GA 1971.

¹⁹⁷ *Bullock County Hospital Association v Fowler*, 183 SE 2d 586, GA 1971.

¹⁹⁸ 223 A.D. 547, 229 N.Y.S. 60 (3 DEPT 1928).

"The defendants were chiropractors who treated plaintiff unskilfully, as a result of which he became paralysed. The court stated that the defendants were illegally practicing medicine in violation of the Education Law so that *"in an action of this kind they must be held to the same standards of skill and care as prevail amongst those who are licensed."*

The court referred to N.Y. Educ. Law §6501(4) which defined the practice of medicine:

"A person practices medicine within the meaning of this article, except as hereinafter stated, who holds himself out as being able to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical condition, and who shall either offer or undertake, by any means or method, to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical condition."

In a later judgement of *Larsen v Yelle*¹⁹⁹ the court was confronted with the following facts:

The plaintiff who had sustained a colles fracture of the right wrist claimed that the defendant, a general practitioner, who had treated him, was negligent in not referring him to a specialist when it was indicated. The plaintiff further claimed that the general practitioner's failure to refer him to the specialist resulted in the loss of usage of the wrist.

The court after assessing the facts stated the legal position as follows:

*"It is true that one of the requirements which the law exacts of general practitioners of medicine is that if, in the exercise of the care and skill demanded by those requirements, such a practitioner discovers, or should know or discover, that the patient's ailment is beyond his knowledge or technical skill, or ability or capacity to treat with a likelihood of reasonable success, he is under a duty to disclose the situation to his patient, or to advise him of the necessity of other or different treatment. If under such circumstances, the general practitioner fails to inform the patient and undertakes to treat what he should refer to a specialist, he will be held to that standard of care required of the specialist. That is, in order to escape liability for injury caused by his treatment, the treatment he himself administered to the patient must at a minimum comply with that degree of skill, care, knowledge and attention ordinarily possessed and exercised by specialists in good standing under like circumstances."*²⁰⁰

From the fore stated it is clear that the Roman doctrine of *imperitia culpa adnumeratur*, as in English and South African Law, still very much forms part of American Law.²⁰¹

6.4.3.3 Legal Opinion

(1) The distinct difference in levels of training, knowledge and skill between a physician and a specialist is widely recognised by the American legal writers and the courts.

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¹⁹⁹ 310 MINN 521 246 WW 2d 841 (1976).

²⁰⁰ See *Larsen v Yelle* 310 MINN 521 246 NW 2d 841 (1976).

²⁰¹ See W. Page Keeton Prosser and Keeton on the *Law of Torts* (1984) 161.

²⁰² Kramer and Kamen *Medical Malpractice* (1983) 5; Holder *Medical Malpractice Law* (1975) 55; McCoid "The Care required of Medical Practitioners" 1959 *Van der Bilt Law Review* 549; Peters et al *The Law of Medical Practise in Michigan* (1981) 156; Southwick and Slee *The Law of Hospital and Healthcare Administration* (1988) 58. For case law see *Beck v Schwezier* 149 SE 2d 565, NO 1966; *Bullock County Hospital Association v Fowler* 183 SE

- (2) The standard and degree of care and skill expected judicially of the specialist is higher than that expected of a general practitioner.²⁰³
- (3) The standard of care of a specialist is however, not the highest standard of care but rather a reasonable standard. The conduct of the specialist is measured against that of the reasonable specialist.²⁰⁴

6.5 LOCALITY WHERE TREATMENT TAKES PLACE

6.5.1 SOUTH AFRICA

6.5.1.1 Legal Writings

From the foregoing it emerged that it is a well-established principle in our law 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.²⁰⁵

The standard of care and skill required of a general practitioner is not the same as those required of a specialist, or vice versa. If the doctor is a specialist, the test is that of the reasonable specialist in terms of the branch of the profession to which he or she belongs. If on the other hand the doctor is a general practitioner to the branch he/she belongs.²⁰⁶

2d 586 GA 1971; *Lansen v Yelle* 310 MINN 521 246 WW 2d 841 (1976).

²⁰³ Waltz and Inbau *Medical Jurisprudence* (1971) 42, 45; Furrow et al *Health Law* (1995) 237; Morris and Moritz *Doctor and Patient and The Law* (1971) 135; *American College Legal Medicine* (1991) 43 62-63; Holder *Medical Malpractice Law* (1975) 3 43. For case law see *Beck v Schweizer* 149 SE 2d 565, NO 1966; *Bullock County Hospital Association v Fowler* 183 SE 2d 586, GA 1971.

²⁰⁴ Rheingold and Daley *Standard of Care in Medical Malpractice Cases* (1975) 16; Holder *Medical Malpractice Law* (1975) 55; Waltz and Inbau *Medical Jurisprudence* (1971) 44; Holder *Medical Malpractice Law* (1975) 43 47; Southwick and Slee *The Law of Hospital and Healthcare Administration* (1988) 57-58; Moore and Kramer *Medical Malpractice: Discovery and Trial* (1990) 7.

²⁰⁵ See the legal writings of Van Oosten (1996) 54-55 82; Claassen and Verschoor (1992) 115; Strauss *Doctor, Patient and The Law* (1984) 306-307; Gordon, Turner and Price (1953) 109; Van Oosten (1986) 18-19 22; McQuoid-Mason and Strauss *LAWSA* (1983) Para 185; Strauss (1991) 72-73 95; Strauss and Strydom (1967) 266; Carstens (1988) 345; Van Dokkum (1996) 792; McKerron (1971) 38; Dada and McQuoid-Mason (2001) 22-23; Carstens and Pearmain (2007) 623.

²⁰⁶ For the legal writings see: Van Oosten *Encyclopaedia* (1996) 83; Claassen and Verschoor (1992) 15; McQuoid-Mason and Strauss *LAWSA* (1983) Par 199; Gordon, Turner and Price (1953) 109, 113; Carstens (1988) 396; Dada and McQuoid-Mason (2001) 22; Boberg (1984) 346; McKerron (1971) 38; Carstens (1996) 137; Strauss and Strydom (1967) 124 268; Carstens and Pearmain (2007) 623.

The geographical situation in South Africa, in which so many hospitals are situated in rural country towns and rural tribal areas, often with very poor infra-structures and inferior diagnostic and other equipment, leads one to pose the question, namely, what standard of care and skill is required of a medical practitioner who practices in the country town or rural tribal area?

Although our legal writers generally recognize the principle that the practitioner who treats the patient in a country town is required to exercise some degree of care and skill towards his or her patient, no unanimity exists, amongst our writers, whether the standard of care and skill expected of the medical practitioner in the country town or rural tribal area ought to be the same as that of the medical practitioner who practices in the city.²⁰⁷ Put

²⁰⁷ See in this regard the unanimity amongst the writers who recognize the principle that the application of the so-called "locality rule" in cases of negligence results in the professional standard expected judicially from medical practitioners being localized with regard to the medical knowledge, care and skill generally accepted in that specific geographical area. See Strauss and Strydom (1967) 268-270; Van der Walt (1979) 71; Boberg (1984) 353 and especially, Gordon, Turner and Price (1953) 112-113. The writers support the principle enunciated in the dictum of Innes C.J. in *Van Wyk v Lewis* (1924) AD 438 at 444 namely: "*The ordinary medical practitioner should 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.*" Relying on the uniform training of doctors in South Africa, Gordon et al (1953) at 112-113 come to the following conclusion: "*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. In the American case of Turner v Stoker, it was said: "Of course, the Court understands that the physician practising in a village and in small communities does not have the opportunities and resources to give the same treatment and diagnosis as what may be called the city physician. The village physician must observe his patient by candle and lamp light; he does not have the advantage of the röntgen ray and other instrumentalities that are afforded in the great cities with sanatoriums."* The authors continue: "*These propositions seem to be eminently reasonable, but when the Court follows them with the proposition "and of course the same treatment and degree of care would not be applied to a physician practising in such a community as to one practising in a city," it must be confessed that it seems to be a non sequitur.*" *Contra Carstens "The Locality Rule in cases of medical malpractice": De Rebus (1990) 421-423. The writer holds the view that a distinction should be drawn between the subjective abilities (such as skill, education and knowledge) and the objective circumstances in which he finds himself in a particular locality. Whilst Carstens acknowledges "the uniformity in the training of medical practitioners today" nevertheless he argues that "the lack of medical facilities and infrastructure in the country towns or rural areas are factors which must be taken into consideration when evaluating a practitioner's conduct in cases of medical malpractice."* The writer continues: "*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 practise in the city or in the country.*" See also the persuasive argument advanced by Carstens and Pearmain (2007) 638 when they state that a distinction should be drawn between the subjective competence and ability of a physician (ability with regard to training, experience and skill), and the objective circumstances of the particular locality where the physician practiced or is employed. Although medical practitioners in South Africa today undergo uniform training, comparable with international standards, it cannot be denied that South Africa is a developing country and in many respects even an emerging or third world country. Further, although the physician may be well qualified and equipped the fact that he/she is placed in a remote rural area without the supporting medical facilities or infrastructure would influence the assessment of the doctor's conduct. The writers suggest that one cannot compare the infrastructure, diagnostic and other equipment for

differently, the question may be begged whether the standard of care and skill expected of the medical practitioner is influenced by the particular locality where the practitioner happens to reside or practice?

6.5.1.2 Case Law

There is no unanimity in our case law whether, the locality where the medical practitioner practices and treats a patient, is relevant when determining his or her professional liability arising from negligence.²⁰⁸

6.5.1.3 Legal Opinion

- (1) There is no unanimity amongst the South African writers whether the standard of care and skill expected of a medical practitioner practicing in, for example, a city, is the same as that of a doctor practicing in a country town.
- (2) It is, however, generally accepted that the medical practitioner who treats the patient in a country town is required to exercise some degree of care and skill towards his or her patient.²⁰⁹

example at Johannesburg General Hospital with the facilities of a mission hospital/clinic in a remote rural area. The aforementioned approach in my mind is the correct approach especially in view of the fact that South Africa is a third world country in which poverty and indigence are dominant.

²⁰⁸ In the *locus classicus* on professional negligence namely *Van Wyk v Lewis* (1924) 438 the court dealt with the so-called locality issue. The court was divided in that different views were expressed. Innes C.J. on the one hand expressed the view that it made no difference where the practitioner practices. The Chief Justice goes on to say: "The ordinary medical practitioner should, as it seems to me, exercise the same degree of skill and care, whether he carries on his work in the town or the country, in one place or another. The fact that several incompetent or careless practitioners happen to settle at the same place cannot affect the standard of diligence and skill which local patients have the right to expect." Wessels J.A. on the other hand adopted a different view, the thrust of his argument being one cannot expect the same care and skill of a medical practitioner doing duty in a country town as opposed to one doing duty in a large hospital in the city. Wessels J.A. at 457 states: "It seems to me, however that you cannot expect the same skill and care of a practitioner in a country town in the Union as you can of one in a large hospital in Cape Town or Johannesburg. In the same way you find with leading surgeons in the large hospitals of London, Paris and Berlin. It seems to me, therefore, that the locality where an operation is performed is an element in judging whether or not reasonable skill, care and judgement have been exercised." The only other case in which the relevance of locality came under discussion is that of *Webb v Isaacs* 1915 (EDL) 273 in which the Court at 276 remarked: "There are excellent reasons for this rule of law, because it seems to me that if the law required in every case that a practitioner should have the highest degree of skill, it would lead to this result, that in remote country districts and even in country districts at no very great distance from the large centres, it would be impossible to find a country practitioner who would take the risk of attending a patient, if he was always expected to exercise the highest degree of skill obtainable in the medical profession."

²⁰⁹ See the legal writings of Van Oosten *Encyclopaedia* (1996) 54-55, 82; Claassen and Verschoor *Medical Negligence* (1992) 115; Strauss *Doctor Patient and The Law* (1984) 306-307; Gordon, Turner and Price *Medical Jurisprudence* (1953) 109; Van Oosten "Professional Medical Negligence in South African Legal Practise" *Medicine and Law* (1986) 18-19 22; McQuoid-Mason and Strauss *Lawsa* (1983) Par 185; Strauss *Doctor Patient and The Law* (1991) 72-73 95; Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 266; Van

- (3) Some writers hold the view that the duty of care and skill placed upon a medical practitioner in the country town or rural tribal area ought to be the same as that of the medical practitioner who practices in the city. ²¹⁰
- (4) More recently, the legal writer, Carstens, persuasively argues that a distinction should be drawn between the subjective abilities such as skill, education and knowledge and the objective circumstances in which the medical practitioner finds himself/herself in a particular locality, which may differ from that of the city. What is especially relevant is lack of medical facilities and infrastructure in the country towns or rural areas. ²¹¹
- (5) The opinion expressed by Carstens, it is submitted, is the preferred view, particularly in view of the prevailing situation in South Africa, a third world country in which poverty and indigency are dominant.
- (6) There is also no unanimity in our case law whether the locality where the medical practitioner practices and treats a patient is relevant in determining the practitioner's professional liability arising from negligence. ²¹²

6.5.2 ENGLAND

6.5.2.1 Legal Writings

In England there is a movement towards developing protocols and, particularly, practice

Dokkum "Medical Malpractice in South African Law" *De Rebus* April 1996; McKerron *The Law of Delict* (1971) 38; Dada and McQuoid-Mason *Introduction to Medico-Legal Aspects* (2001) 22-23; Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 636ff.

²¹⁰ Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 268-270; Van der Walt *Delict: Principles and Cases* (1979) 71; Boberg *The Law of Delict* (1984) 353; Gordon Turner and Price *Medical Jurisprudence* (1953) 112-113. Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 636ff. The afore stated writers rely heavily on the dictum of Innes CJ in *Van Wyk v Lewis* (1924) AD 438 at 444 in reaching their view.

²¹¹ Carstens "The Locality Rule in cases of Medical Malpractice" *De Rebus* (1990) 421-423; See also the well motivated argument presented by Carstens and Pearmain (2007) 638.

²¹² In the *locus classicus* on professional negligence namely *Van Wyk v Lewis* (1924) 438 the court was divided in deciding whether the locality rule ought to be adopted or not. Innes CJ on the one hand expressed the view that it made no difference where the practitioner practices, the same degree of skill and care is required to be exercised. Wessels JA on the other hand, adopted a different view namely one cannot expect the same care and skill of a medical practitioner doing duty in a country town as opposed to one doing duty in a large hospital in the city. See also the case of *Webb v Isaacs* 1915 (EDL) 273 in which the court held there ought to be a distinction between the standard of conduct between the country town practitioner and that of the practitioner of the city.

guidelines, the aim of which is to standardize medical responses and inform doctors (and others) of the available options to treat patients. ²¹³

The obligations imposed by the 1992 Regulations have also assisted in providing uniformity in determining the scope and content of the doctor's duty at common law, regardless of where they practice. ²¹⁴

Another way of ensuring uniformity in the medical profession, in England, is the obligation placed on doctors to keep up to date with the new developments in their particular field. ²¹⁵

6.5.2.2 Case Law

Although the English Courts have recognised the challenges facing medical practitioners, in practice, in keeping abreast with new developments in their particular field and to make a reasonable effort to keep up to date, ²¹⁶ nevertheless, the courts have been very cautious in blaming medical practitioners from doing so arbitrarily. ²¹⁷

In the case of *Thompson v Smith Ship Repairers (North Shields) Ltd* ²¹⁸ Mustell J stated:

"That where a practitioner practises medicine but is slow in initiating or seeking out knowledge of facts which are not really relevant to him, "the court must be slow to blame him for not ploughing a lone furrow" "

In *Lawford v Charing Cross Hospital* the facts were the following: the Plaintiff developed brachial palsy in an arm following a blood transfusion. In the court a quo the defendant's were held liable on the basis that the anaesthetist had failed to read an article published in the Lancet six months earlier, concerning the best position of the arm when using a drip.

²¹³ See Kennedy (1998) 284.

²¹⁴ See Kennedy (1998) 295.

²¹⁵ See Kennedy (1998) 353-354. Though the writer recognizes that a doctor cannot realistically be expected to read every article in every medical journal, where a particular risk has been highlighted on a number of occasions "the practitioner will ignore it at his peril."

²¹⁶ See *Stokes v Guest, Keen & Nettlefold (Bolts & Nuts)* (1968) 1 WLR 1 776 at 783 in which Swanwick J remarked: "*Where there is developing knowledge, (the defendant) must keep reasonably abreast of it and not be too slow to apply it.*"

²¹⁷ See *Roe v Minister of Health* (1954) 2 QB 66 in which the court cautions that although a doctor cannot realistically be expected to read every article, where a particular risk has been highlighted on a number of occasions the practitioner will ignore it at his peril.

²¹⁸ (1953) the Times 8 December.

On appeal the Court of Appeal reversed this decision, taking the view that it would be too great a burden to require a doctor to read every article appearing in the current medical press. The Court of Appeal also found it was wrong to suggest that a practitioner was negligent simply because he did not immediately put into operation the suggestions made by the contributor to the medical journal. Although the time might come when a recommendation was so well proved and so well accepted, that it should be adopted.

In *Gascozne v Ian Sheridan & Co*²¹⁹ Mitchell J commented that a 'shop floor gynaecologist' had a responsibility to keep himself generally informed on mainstream changes in diagnosis, treatment, and practice through the mainstream literature, such as the leading textbooks and the Journal of Obstetrics and Gynaecology. The court found it was, however, unreasonable to suppose that he had had an opportunity to acquaint himself with the contents of obstetrics journals.

6.5.2.3 Legal Opinion

- (1) England, being a first world country, makes no distinction in the practice of medicine between a medical practitioner practicing medicine in the city as opposed to one who practices medicine in a country town.
- 2) Protocols and practice guidelines have been developed in England and adopted which bring about a uniform standard of the doctor or specialist duty of care, regardless of where they practice.²²⁰
- (3) Doctors and specialists in this way are expected to keep abreast with the new developments in their particular fields.²²¹

6.5.3 UNITED STATES OF AMERICA

6.5.3.1 Legal Writings

Until quite recently, the so-called, 'locality rule' was recognised and applied as a matter of

²¹⁹ (1994) J. MED. L.R. 437-447.

²²⁰ See Kennedy *Treat me Right-Essays in Medical Law and Ethics* (1998) 284-295.

²²¹ See Kennedy *Treat-me-Right Essays in Medical Law and Ethics* (1998) 353-354. For case law see *Stokes v Guest, Keen & Nettlefold (Bolts & Nuts)* (1968) 1 WLR 776 at 783. But warns the courts the doctor cannot realistically be expected to read every article where a particular risk has been highlighted. See *Roe v Minister of Health* (1954) 2 QB 66; *Thomson v Smith Ship Repairers (North Shields) Ltd* (1953) The Times 8 December 1953; *Lawford v Charing Cross Hospital* (1994) J.MED L.R. 437-447.

law in the United States of America.²²²

The 'locality rule' operates by applying the standard test in comparing the due care and skill exercised by the particular physician in reference to that of other physicians in his geographical area.²²³

What is of significance is that the skill and knowledge of a physician practicing in, for example, an isolated rural area was, in theory, not put on the same plateau as the well trained and up-to-date physician who found himself/herself practicing in an urban environment.

Although it is generally accepted that in medical malpractice cases regard will be had to the physical and geographical circumstances of each case,²²⁴ it does not appear that the 'locality rule' is really used any longer in American Law.²²⁵

Alternatively the rule has been watered down significantly, in that, there is broad consensus amongst the writers that there ought to be a movement away from the rule and that a uniform standard be created and enforced at national level.²²⁶

²²² See Holder (1975) 53; Alton (1977) 22; See also Hoffman "Medical Malpractice" A Chapter in *American College of Legal Medicine* (1991) 132-133; Furrow et al (1995) 238; Waltz and Inbau (1971) 67-68.

²²³ See Holder (1975) 53 who states that traditionally the standard test was "*that degree of care which other physicians exercise in the same or similar communities*"; Other writers including Alton (1977) 22 following the Pike decision formulates the standard of care of the physician as "*that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons in the locality where he practises*." See also Hoffman - "Medical Malpractice" A chapter published in *American College of Legal Medicine* (1991) 133 who equates the standard of care with the standard of care in the "same locality" or "similar locality". A similar equation is used by Waltz and Inbau (1971) 64 in which they claim: "*We usually say, today, that a medical man has the obligation to his patient to possess and employ such reasonable skill and care as are commonly had and exercised by reputable, average physicians in the same general system or school of practice in the same or similar locality*." See also Southwick (1988) 54. The author describes the 'locality rule': "*That rule which measures the standard of care in a given instance solely by the practices of other physicians in the same locality*." Locality in this regard according to the author 54 footnote 8 means: "*The same community or a wider area which is still in the general vicinity where the physician practises. The term is generally used in contrast to a national standard*." See further Furrow et al (1995) 238. The writers base the standard: "*..... on the local community or a similar community*."

²²⁴ See Holder (1975) 53; see also Waltz and Inbau (1971) 64 who express the view that the justification for the original formulation of the so-called 'locality rule' was based on the presumption that: "*The rural and small-town practitioner was less adequately informed and equipped than his big-city brother*."

²²⁵ See Alton (1977) 21. The author recognizes that in certain instances regard would be had to: "*The absence of sophisticated machinery for the treatment of the patient in smaller communities*." See also Furrow et al (1995) 238. The authors advocate that in certain instances the "*..... Trier of fact will be allowed to consider the facilities, staff and equipment available to the practitioner in the institution*." Waltz and Inbau (1971) 67 also recognize that in certain instances "*the lack of equipment and facilities available to the physician in his particular locality would be a factor that the judges could take into account in assessing the propriety of his conduct*."

²²⁶ See Waltz and Inbau (1971) 64 who advocate that: "*The 'locality rule' is about to disappear almost completely*." See also Furrow et al (1995) 238. The authors believe "*most jurisdictions have moved from the 'locality rule' to a*

The original application of the 'locality rule' impacted upon the nature and scope of medical evidence presented by experts in malpractice litigation. In this regard, in its original formulation, the 'locality rule' literally demanded that a medical expert testifying for the plaintiff in a malpractice action must have practiced in the defendant's community.²²⁷

The underlying reason therefore stems from the fact that a physician from another geographical area would not be familiar with the circumstances of the area in which the defendant finds himself. Therefore, for example, a general practitioner practicing in New York City would not be defined to possess the expertise of a practitioner practicing in Dry Gulch, New Mexico with a population of 600.²²⁸

Likewise, although two cities may be situated in two geographical areas, 22 miles apart, a general practitioner practicing in one may not testify regarding the acceptable practices in the other.²²⁹ This clearly led to absurd results. For that reason the American legal writers have taken the stance that, notwithstanding the general practitioner's locality where he/she practices, with nationwide advances in medical training, uniform practices and the improvement in communications, his/her evidence as an expert may be used to prove negligence in malpractice cases involving a general practitioner in another geographical area.

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national standard." See further Hoffman "Medical Malpractice" - a chapter published in American College of Legal Medicine (1991) 133. According to Hoffman, "with improved medical facilities and board certification, the 'locality rule' for medical negligence has been abandoned in many jurisdictions." See further Holder (1975) 54 who holds the opinion that physicians in small towns should not rely upon the 'locality rule' and so gain advantage "in being a little more careless."

²²⁷ See Waltz and Inbau (1971) 65 who advocates the relaxing of the 'locality rule' the main reasons being: "The nationwide advances being made in medical training, the method and scope of instructions as well as the improvement of communications and transportation." The authors continue: "There is also the free exchange of scientific information and the consequent tendency to harmonize medical standards throughout the country." See also Pozgar (1996) 41-42. See also Furrow et al (1995) 238; See further Hoffman "Medical Malpractice" - A chapter published in *American College of Legal Medicine* (1991) 133; *Contra* Holder (1975) 54-55 who opine that many states still apply the 'locality rule' to general practitioners, however, with specialists "national standards are applied". See further Southwick (1988) 55.

²²⁸ See Waltz and Inbau (1971) 64; Furrow et al (1995) 242; See also Pozgar (1996) 41; Waltz and Inbau (1971) 46.

²²⁹ See *Coburn v Moore* 68 NE 2d 5 (MASS) (1946) In this case the Supreme Court of Massachusetts decided in 1940 that a general practitioner who practices in Boston may not give expert evidence in respect of alleged negligence against a general practitioner practicing in Brocton some 22 miles from Boston.

²³⁰ See Waltz and Inbau (1971) 67-68; See also Furrow et al (1995) 242; See further Holder (1975) 54 who expresses the view that: "In most jurisdictions today, the local standard of practice is considered only one factor presented for the jury's determination and is not in and of itself determinative of the presence or absence of negligence." There is therefore no reason why the general practitioner cannot give evidence as an expert.

6.5.3.2 Case Law

The American courts, through the years, have had ample opportunity to consider the application of the 'locality rule'. In one of the first cases *Murphy v Little*,²³¹ the court looked at various factors influencing the existence of the 'locality rule' and concluded:

*"Reasons for the more narrow rule which might have been obtained in the time past, where transportation was difficult, medical schools and hospitals often inaccessible and doctors licensed to practice with little or no formal training, no longer have any validity. Medical practitioners frequently receive a part or all of their education in states other than the one in which they settle to practice. There are doubtless areas of medicine where knowledge of proper treatment is limited geographically by prevalence of the disease or by reason of special facilities for study, but the human race has suffered from broken bones for as long as it has been in existence."*²³²

In one of the most frequently quoted decisions dealing with medical negligence in America, namely *Pike v Honsinger*,²³³ the court of appeals of New York, reversing the decision of the Lower Court and ordering a new trial, stated that:

"A physician impliedly represents that he possesses that reasonable degree of learning and skill ordinarily possessed by physicians in the locality. Furthermore, the court held, "it becomes his duty to use reasonable care and diligence in the exercise of his skill and his learning."

But, continues the court:

*"He is bound to keep abreast of the times, and departure from approved methods and general use, if it injures the patient, will render him liable. Finally, the court required the physician to give "proper instructions to his patient in relation to conduct, exercise, and use of an injured limb."*²³⁴

The advancement of medical science, uniform training provided for trainee physicians at medical schools in America, greater mobility in the medical sphere and a more effective geographical distribution of medical knowledge in the medical profession, are all contributing factors why the 'locality rule' is not effectively enforced today.

In the case of *Montgomery v Stary*²³⁵ the Supreme Court of Florida commented as follows on the development of the medical profession in general:

"This rule (i.e. the locality rule) was originally formulated when communications were slow or virtually non-existent and it has lost much of its significance today with the increasing number and excellence of medical schools,

²³¹ 112 GA APP (1965) 517 145 SE 2d 760.

²³² *Murphy v Little* 112 GA APP (1965) 517 145 SE 2d 760.

²³³ 49 N.E. 716 (1898).

²³⁴ *Pike v Honsinger* 49 N.E. 716 (1898).

²³⁵ 84 SO.2d 34 (S. CT.FLA. 1955).

the free interchange of scientific information, and the consequent tendency to harmonize medical standards throughout the country." ²³⁶

In the case of *Viita v Dolan* ²³⁷ the court commented as follows on the narrowing of the gap between the country doctor and that of city doctor:

"Frequent meetings of medical societies, articles in the medical journals, books by acknowledged authorities, and extensive experience in hospital work put the country doctor on more equal terms with his city brother. He would probably resent an imputation that he possessed less skill than the average physician or surgeon in the large cities, and we are unwilling to hold that he is to be judged only by the qualifications that others in the same village or similar villages possess." ²³⁸

In *Zills v Brown* ²³⁹ the broader standard is preferred as a substitute for the traditional rule.

The court highlights various reasons for the 'locality rule's' disappearance:

"Locality rules have always had the practical difficulties of: (1) a scarcity of professional people in a locality or community qualified to testify; and (2) treating as acceptable a negligent standard of care created by a small and closed community of physicians in a narrow geographical region. Distinction in the degree of care and skill to be exercised by physicians in the treatment of patients based upon geography can no longer be justified in light of the presently existing state of transportation, communications, and medical education and training which results in a standardization of care within the medical profession. There is no tenable policy reason why a physician should not be required to keep abreast of the advancements in his profession." ²⁴⁰

With regard to the practice of hospitals, irrespective of where they are situated, the courts in America have increasingly adopted the view that the practice of medicine should be national in scope.

In *Dickenson v Mailliard* the court stated:

"Hospitals must now be licensed and accredited. They are subject to statutory regulation. In order to obtain approval they must meet certain standard requirements. It is no longer justifiable, if indeed it ever was, to limit a hospital's liability to that degree of care which is customarily practised in its own community. Many communities have only one hospital. Adherence to such a rule, then, means the hospital whose conduct is assailed, is to be measured only by standards which it has set for itself." ²⁴¹

The parents, in *Wickliffe v Sunrise Hospital*, sued the hospital for the wrongful death of

²³⁶ *Montgomery v Stary* 84 SO 2d 34 (S. GT.FLA.1955).

²³⁷ 132 Minn. 128 155 NW 1077 (1916).

²³⁸ *Viita v Dolan* 132 Minn. 128 155 NW 1077 (1916).

²³⁹ 382 So. 2d 528, 532 (ALA.1980).

²⁴⁰ *Zills v Brown* 382 So. 2d 528, 532 (ALA.1980).

²⁴¹ *Dickenson v Mailliard* 191 ILL. 374 153 NE.

their teenage daughter, who suffered respiratory arrest while recovering from surgery. The Supreme Court of Nevada held that the level of care to which the hospital must conform is a nationwide standard. The hospital's level of care is no longer subject to narrow geographic limitations under the so-called locality rule; rather, the hospital must meet a nationwide standard.²⁴²

The principle and the 'locality rule' in general, were given the death knell in 1968 in the case of *Brune v Belinkoff*.²⁴³ The court held:

*"We are of the opinion that the 'locality rule' of Small v Howard which measures a physician's conduct by the standards of other doctors in similar communities is unsuited to present day conditions. The time has come when the medical profession should no longer be Balkanized by the application of varying geographic standards in malpractice cases. Accordingly Small v Howard is hereby overruled. The present case affords a good illustration and the inappropriateness of the locality rule to existing conditions. The Defendant was a specialist practising in New Bedford, a city of 100 000 which is slightly more than 50 miles from Boston, one of the medical centres of the nation, if not of the world. This is a far cry from the country doctor in Small v Howard, who ninety years ago was called upon to perform difficult surgery. Yet the trial court judge told the jury that the skill and ability of New Bedford physicians were fifty percent inferior to those obtained in Boston. The Defendant should be judged by New Bedford standards, 'having regard to the current state of advance of the profession'. This may well be carrying the rule in Small v Howard to its logical conclusion, but it is we submit a reductio ad absurdum of the rule."*²⁴⁴

But, notwithstanding the definite rejection of the so-called 'locality rule' by the American Courts, some courts in America continued to disregard the expert evidence of medical practitioners, in instances where they testify in medical negligence cases regarding the conduct of another practitioner in another geographical area. In this regard the Supreme Court of Mississippi, as recently as 1983, in the case of *King v Murphy*,²⁴⁵ held that the evidence of an experienced orthopaedic surgeon who practices in Florida, Miami, is inadmissible in that the surgeon from Florida is not familiar with the acceptable medical practice in Mississippi.

This decision resulted in severe criticism. In a water-shed case, the Supreme Court of Mississippi, in the case of *Hall v Hilburn*,²⁴⁶ settled the issue in preferring a national medical standard above the local medical standard, espoused by supporting of the 'locality rule'.

²⁴² *Wickliffe v Sunrise Hospital 1 W.L.R. 246.*

²⁴³ 235 NE 2d 793 (MASS).

²⁴⁴ *Brune v Belinkoff* 235 NE 2d 793 (MASS).

²⁴⁵ 424 So 2d 547 (MISS 1983).

²⁴⁶ 466 So 2d 856 (MISS 1985).



The court remarks as follows:

"We would have to put our heads in the sand to ignore the nationalization of medical education and training. Medical school admission standards (and curricula) are similar across the country. Internship and residency programs for those entering medical specialties have substantially common components. Nationally uniform standards are enforced in the case of certification of specialists. Physicians are far more mobile than they once were. They have ready access to professional and scientific journals and seminars for continuing medical education from across the country. The medical centres in Memphis, Birmingham, Mobile, New Orleans and other nearby areas in adjoining states are a very real part of the Mississippi-centred universe of hospitalization, medical care and treatment and other health related services. All above informs our understanding and articulation of the competence-based duty of care. The content of the duty of care must be objectively determined by reference to the availability of medical and practical knowledge which would be brought to bear in the treatment of like or similar patients under like or similar circumstances by minimally competent physicians in the same field, given the facilities, resources and options available. The content of the duty of care may be informed by local custom but never subsumed by it. Generally, where the expert lives or where he or she practices his or her profession has no relevance per se with respect to whether a person may be qualified and accepted by the court as an expert witness." ²⁴⁷

Although the 'locality rule' in respect of the competency of a medical expert in medical negligence cases is no longer rigidly applied, according to the Hall decision, the unique circumstances of each case may be an influencing factor in deciding medical negligence cases in America.

6.5.3.3 Legal Opinion

- (1) The so-called 'locality rule' was until quite recently recognized and applied as a matter of law in the United States of America. ²⁴⁸
- (2) The 'locality rule' operated by applying a different standard of care and skill in respect of physicians and surgeons, depending on the locality where they practice. ²⁴⁹
- (3) But in time, the 'locality rule' has been watered down, so much so, that there is broad consensus amongst the legal writers and the courts that, because of the wide-run standard created at material level, there is a movement away from the

²⁴⁷ *Hall v Hillburn* 466 So 2d 856 (MISS 1985).

²⁴⁸ Holder *Medical Malpractice Law* (1975) 53; Hoffman 'Medical Malpractice' A Chapter in the *American College of Legal Medicine* (1991) 132-133; Furrow et al *Health Law* (1995) 238, Waltz and Inbau *Medical Jurisprudence* (1971) 67-68. For the recognition of the locality rule in case law see *Murphy v Little* 112 GA APP (1965) 517 145 SE 2d 760; *Pike v Honsinger* 49 N.R. 716 (1898).

²⁴⁹ Holder *Medical Malpractice Law* (1975) 53; Hoffman 'Medical Malpractice' A Chapter in the *American College of Legal Medicine* (1991) 133; Furrow et al *Health Law* (1995) 238, Waltz and Inbau *Medical Jurisprudence* (1971) 67-68; Southwick and Slee *The Law of Hospital and Healthcare Administration* (1988) 54; For case law see *Murphy v Little* 112 GA APP (1965) 517 145 SE 2d 760; *Pike v Honsinger* 49 N.R. 716 (1898).

rule.²⁵⁰

6.6 Summary and Conclusions

It is evident from the chapter that the doctor/hospital's general duty of care is a significant component of the doctor/hospital-patient relationship. The doctor/hospital's general duty of care arises even in the absence of a contractual agreement. The rationale for the existence of the doctor/hospital's duty of care towards his/her/its patient has been stated before, namely, it serves as a protective measure in preventing harm to the patient and to act in the patient's best interest. Where the doctor/hospital fails in this duty he/she/it faces liability at the hands of the law.

The origin of the doctor/hospital's duty of care is founded in normative ethics and complemented by various ethical codes, regulations and the Hippocratic Oath itself.

In terms of the ethics of the profession it appears that, in general terms, the doctor is under a duty to act and to treat a patient. It is also evident that, traditionally, the doctor/hospital could not incur criminal or delictual liability merely by virtue of such a refusal. This stemmed from the traditional approach that a person could not be held liable by virtue of a mere omission. But in modern day, the situation has changed, as, today, it is generally accepted that a mere omission can, in fact, lead to delictual, as well as criminal liability, where the circumstances are such that the doctor/hospital concerned could be expected to intervene.

It is also evident from the chapter that the nature of the general duty of care is to exercise reasonable care. But, the duty to exercise reasonable care does not include a successful outcome of the procedure or treatment embarked upon, nor does he/she/it guarantee the outcome, unless the doctor/hospital guarantee such result. It is only in the latter instance that the doctor/hospital may incur liability, if he/she/it does not successfully provide the procedure or treatment undertaken.

It is further evident from the chapter that it is generally accepted that the work of the doctor/hospital requires some form of skill. The standard of care and skill required of the

²⁵⁰ Waltz and Inbau *Medical Jurisprudence* (1971) 64-65; Furrow et al *Health Law* (1995) 238; Hoffman "Medical Malpractice" A Chapter published in the *American College of Legal Medicine* (1991) 133; Holder *Medical Malpractice Law* (1975). The American courts have also decided in a number of cases against the usage of the 'locality rule'. The advancement of medical science, uniform training standards for trainee physicians at medical schools and the more effective geographical distribution of medical knowledge in the medical profession are all factors that influenced the American Courts. See *Montgomery v Stary* 84 SO 2d 34 (S.CT.FLD 1955); *Viita v Dolan* 136 MINN 128 155 NW 1077 (1910); *Zills v Brown* 382 SO 2d 528, 532 (ALA 1980); *Dickenson v Maelliard* 191 ILL 374 153 NE; *Wickliffe v Sunrise Hospital 1 W.L.R 246.*; *Brune v Belinkoff* 239 NE 2d 797 (MASS); *Hall v Hilburn* 466 So 2d 85 (MISS 1985).

doctor/hospital is not that of the ordinary man in the street, or as has been accepted in the legal parlance, the hypothetical or fictitious reasonable person. The standard of care is somewhat elevated to the branch of the profession to which he/she belongs. What is required is a more subjective test in which the conduct of the doctor/hospital is measured in terms of the reasonable doctor or reasonable specialist or reasonable hospital, depending on which branch of the medical field is applicable.

It is also evident from this chapter that the term 'reasonable' in the medical context does not call for the highest possible degree of professional care and skill but rather the ordinary or average standard, expected of a professional person, with the general level of knowledge, ability, experience, care, skill and diligence. Therefore, by embarking upon a procedure of treatment of the patient, the doctor/hospital, by implication or impliedly, represents to the patient that he/she/it has the necessary training, knowledge and skill and that he/she/it will employ same.

As alluded to earlier, the conduct of the ordinary medical doctor in medical negligence cases is adjudged differently from that of a specialist. A clear distinction is made between the experience levels, level of knowledge and the degree of care and skill required from a general medical practitioner as opposed to the specialist. Of the specialist is expected a greater degree of skill than that of the general medical practitioner. Nonetheless, the conduct of the specialist is measured against the average of reasonable specialist attached to the branch of the profession he or she belongs to.

The standard of conduct of the general doctor or specialist in South Africa is also influenced by the geographical situation in the country, given the facilities in the rural country towns and rural tribal areas, often with poor infra-structures and inferior diagnostic and other equipment, differs markedly from that found in the cities. Although there is no unanimity, it does appear that the preferred view is that a distinction ought to be drawn between the subjective abilities such as skill, education and knowledge and the objective circumstances in which the medical practitioner finds himself/herself in a particular locality, which may differ from that of the city. What is especially relevant is lack of medical facilities and infrastructure in the country towns or rural areas.

The same position clearly does not exist in the other jurisdictions chosen for the research undertaken with this thesis.

The following chapter will consider whether the doctor/hospital, in any way, limit or exclude



it/his/her general duty of care, given the fact that the doctrine of *volenti fit non iniuria* and the concept “assumption of risk” are generally recognised, in the law of delict, as grounds of justification or defences in the general sense. What will be considered is whether, in the medical field, a doctor/hospital may limit or exclude his/her/its liability, which would otherwise have been regarded as tortuous or delictual conduct.



CHAPTER 7

LIMITING OR EXCLUDING THE DOCTOR/HOSPITAL'S GENERAL DUTY OF CARE

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7.1 Introduction

In the preceding Chapter it was made clear that in South Africa, England, United States of America and other jurisdictions, the concept 'duty of care', is deeply embedded in their law, be it an expressed or implied duty of care derived from contract or that the duty of care prevails in the general sense. What was also observed from the preceding Chapter is a standard of care is created, arising from the special relationship between the doctor/hospital

and patient. Members of the medical profession/hospital are expected to respect honour and observe a reasonable standard of care. They may be held liable in law, for their failure to observe the duty to take care. Despite the aforesaid, it is common cause that all the fore stated jurisdictions have safety mechanisms in place, commonly known as defences. These defences include, but are not restricted to, the doctrines of *volenti non fit iniuria* and voluntary assumption of risk.

In this Chapter, an investigative discourse is conducted on whether the doctor's/hospital's duty of care may in any way be limited or excluded. This discourse will take place against the background of the recognized defences including *volenti non fit iniuria* and voluntary assumption of risk, which are widely recognized in the jurisdictions of England, the United States of America, as well as, South Africa. From the discussions that follow it is clear, that the main purpose for the existence of the defences is said to relieve a person of what would otherwise have been regarded as tortuous or delictual conduct. The effect thereof is that the defendant finds himself/herself exonerated from liability, or put differently, relieved of a legal duty to the plaintiff. The doctrines of *volenti non fit iniuria* and voluntary assumption of risk, which serve as grounds for jurisdictions, therefore, in general terms, to limit or exclude the duty of care, in appropriate circumstances.

It is clear that these defence mechanisms are not new concepts. The doctrine of *volenti non fit iniuria* has its origin in the classical Roman times and was received in English law in the early 14th century.¹ Since then the maxim has been accepted in many common law

¹ Strauss: "Toestemming tot benadeling as verweer in die Strafreg en die Deliktereg". A doctoral thesis (University of South Africa) (1961) 2-6. The author takes the view that, although the maxim in its present wording does not appear in the Roman sources, nevertheless, the closest formulation thereof appears in the *Corpus Iuris Civilis* in which Ulpianus writes: "*nulla iniuria est quae in volentem fiat*". See also the *Digesta* D.47.10.1.5. Strauss (1961) 1 in demonstrating the principle, in consenting one may exonerate another party from liability. The writer uses the example of a Roman who consents to him losing his freedom by being sold as a slave. In that event he exonerates the purchaser against any liability. The Canon Law formulated the maxim as: "*scienti et consentienti non fit iniuria neque dolus*". See *Sext. V, De Regulis Iuris*, 28. See also the writings of Winfield on *Torts* (1954) 27 who states the maxim in its present form *volenti non fit iniuria* can be traced back to a reportable English decision in the year 1305. See also *De Legibus Angliae Ed. Woodbine* (1942) 286. The most common English translation of the maxim *volenti non fit iniuria*. According to Prosser *Handbook of the Law of Torts* (1955) 82 is founded in "*to one who consents no wrong is done*". See also Strauss (1961) 1-2 who, when comparing the writings of the Roman Dutch jurists Voet, Matthaeus and Schorer prefers Schorer's formulation of *volenti non fit iniuria* which has the closest resemblance to the modern day formulation. De Groot 3.35.8 formulated the principle as follows: "*Die willig werdt beschadigt niet gehouden en werd voor beschadigt*" whilst Moorman in 6.1.3.3 himself formulated the principle as: "*Dat niemandt met zynen wil ongelyk wordt aangedaen.*" Strauss *Toestemming tot Benadeling* (1961) 5 translates the maxim *volenti non fit iniuria* in Afrikaans as: "*Aan hom wat wil (willig is) geskied geen onreg nie.*" Literally translated in English it means 'no man can complain of an act which he has expressly or impliedly consented to'. Carstens and Pearmain (2007) describes the maxim of *volenti non fit iniuria* as "*no harm is done to someone who consents thereto*". The authors describe the maxim as the most important legal ground of justification, subject off course to the legal requirements and exceptions.

jurisdictions including England, the United States of America and South Africa. ²

In so far as the doctrine of *volenti non fit iniuria* is concerned, the rationale underlying the recognition of the maxim is strongly based on individualism, in which the individual is left to work out his/her own destiny. The courts are, therefore, not keen to protect the consenting party against his/her own folly in permitting others to do him/her harm. It has been stated, many times before, that a person who willingly consents to the defendant's act, in the form of either a specific harmful act or an activity involving a risk of harm, cannot complain that a delict has been committed against him or her.

The maxim "voluntary assumption of risk", equally has a long history. This defence, which is also regarded as a manifestation of the spirit of individualism, has its roots in the English common law centuries ago. Its origin is said to stem from the protection which the doctrine afforded employers, in a capitalist environment, against potential claims arising from the injuries sustained by employees, arising from the wrongdoings of other employees. The doctrine, as with *volenti non fit iniuria*, is firmly entrenched in that jurisdiction. ³ In time however, this defence found disfavour amongst the courts and the legal writers alike, especially in England, as it was perceived to bring about 'monstrous' results. Monopolies and the powerful were seen in triumph against the poor and vulnerable. ⁴

² Strauss (1961) 3. The writer states that this doctrine after its reception in the different legal systems has been deeply entrenched in the English, American and South African respective legal systems. The maxim, according to Strauss (1961) 5, centres around the *volenti* principle which, is known in English and American Law as "consent". In English Law the word "assent" is used synonymously with the word "consent". In American Law the American Restatement (Torts) Par.49 (a) makes a distinction between the two terms. In this regard whilst "assent" emphasizes the manifestation of a person's willingness without making the act legal, with "consent" on the other hand it constitute "an assent" given under the circumstances makes it legally effective. Strauss (1961) 5 emphasizes the South African legal system has followed the English Law concept resulting in the maxim being based on "consent".

³ Strauss (1961) 68; See also Bohlen "Voluntary Assumption of Risk", 20 *Harvard Law Review*, (1910) for the reception of this maxim in the American Law and the results it brought with the advancement of industry and business. The maxim as early as 1943 found favour with the American Courts. The Supreme Court decision of *Tiller v Atlantic Coast Line Ry. Co* 318 U.S. 54 (1943) 49 acknowledges the rationale for the existence of the doctrine as follows: "To insulate the employer as much as possible from bearing the 'human overhead' which is an inevitable part of the cost - to someone - of the doing of industrial business." The American legal writers followed the same path as the courts in preferring the maxim 'assumption of risk' to that of the doctrine of *volenti non fit iniuria*. See Strauss (1961) 68. See also Bohlen (1910) 63.

⁴ Strauss (1961) 68-69; See also James "Assumption of Risk" *Yale Law Journal* (1952) 141 153. James recognizes the existence of the maxim as "the strengthening of the notion of social insurance and techniques for effecting broad distribution of enterprise liability." The curtailment of the wide use of the maxim is described by Street *The Law of Torts* (1955) 173, as, "social attitudes, with increased paternalism and reaction against *laissez-faire* make unlikely the success of the defence in suits against their employers." See further Peterson "The Joker in the Federal Employers Liability Act, 80" *Central Law Journal* (1915) 5.

The application of the maxim *volenti non fit iniuria*, in its general application, is not applied carte blanche without some restriction being placed on the maxim. In certain instances restrictions or limitations are placed on the successful utilization of the defence. From the discourse in this Chapter, it is clear, that, in order to successfully rely on this defence, certain requirements must first be met. In this regard, the consent of the party who consented to the harm, or consented to run the risk of intentional harm, is of paramount importance. For consent to operate successfully as a defence, certain requirements must first be satisfied, *inter alia*, the consenting party must have had knowledge and been aware of the nature or extent of the harm or risk; its use must be recognized by law and not be regarded as *contra bonos mores*. Consent to harm or the risk of harm will, however, not escape sanction from our courts where the prevailing convictions of the community question the lawfulness of such consent.

The factors which often sway the legal convictions of the community, as will be seen from the discussions, include the nature and extent of the interest involved, the motives of the parties and the social purpose of the consent or assumption of risk. Another independent factor, which some of the writers hold to influence societal convictions, is the so-called 'contracting out of liability' cases. Such an attempt is viewed by some courts and writers alike as grossly unprofessional and, therefore, void, as they are seen as being against public policy.⁵

It is clear from the discourse in this Chapter that, in England, the legal writers and the courts have made it quite clear that in consenting to the risk of injury, the plaintiff does not necessarily consent to negligence, nor does he/she consent to an illegal act or agreement which is against public policy.

The English Unfair Contract Terms Act 1977, impacts on *volenti non fit iniuria* as a defence, as, the Act prohibits clauses which are aimed at, excluding or limiting liability or breach of a duty of care, resulting in death or personal injuries.

⁵ Van der Walt and Midgely Delict: *Principles and Cases* (1997) 69-70. The writers ascribe the restrictions placed on consent in certain instances as influenced by the prevailing legal convictions of the community. See also Gordon et al (1953) 188-189. The writers are especially critical of the so-called 'contracting out of liability cases.' The inclusion of a clause in a contract releasing a practitioner from any legal obligation to show due skill and care, would, be grossly unprofessional. Gordon et al (1953) 188-189 suggest courts should regard those contracts as void and against public policy. For a similar view see Van Oosten Encyclopaedia (1986) 88; Claassen and Verschoor (1992) 102-103; Strauss and Strydom (1962) 175ff, 209ff; Van der Merwe and Olivier (1989) 92-93; Joubert *The Law of South Africa* Vol. 8 (1995) 116-117; Boberg *The Law of Delict* (1984) 729. Neethling, Potgieter and Visser *Law of Delict* (2001) 82-83. For case law see the case of *Morrison v Anglo Deep Gold Mines Ltd* 1905 TS 775.

Likewise, in the United States of America, both the American legal writers and the courts do recognise the doctrine of *volenti non fit iniuria* as a defence. Consent is also regarded as an important element of the defence. The effect of consent in this context is, it negates the wrongful event of the defendant's act and deprives the plaintiff of a civil claim afterwards. But, the use of the defence is also restricted or limited; this is usually the case when public interest is contravened.

It will be seen in this Chapter that voluntary assumption of risk as a defence is also recognised in the jurisdictions of South Africa,⁶ England⁷ and the United States of America.⁸ The effect of voluntary assumption of risk as a defence, like that of consent, negates wrongfulness. The legal writers and the courts alike lay down certain requirements which must first be met before it can be said that voluntary assumption of risk has succeeded as a defence.

In this regard, it must be shown that the plaintiff had knowledge of the risk of harm, and that the plaintiff appreciated the nature and extent of the risk involved and notwithstanding, freely and voluntarily assumed the risk.

In America in particular, restrictions or limitations are placed on this form of defence, especially, where the parties stand in an unequal bargaining position to each other, or,

⁶ Some writers in South Africa have expressed the view that 'voluntary assumption of risk' is an extension of the doctrine of '*volenti non fit iniuria*' in that it takes the wider form. See Van Oosten *The Doctrine of Informed Consent* (1989) 14; Van der Walt (1979) 51; McKerron (1971) 67; Van der Walt and Midgley (1997) 68; Joubert *LAWSA* Volume 8 (1995) Par 89. *Contra*, Van der Merwe and Olivier (1989) 95. The writers opine that voluntary assumption of risk does not involve itself with consent to harm *per se* but rather consent to the risk of harm; Boberg (1984) 724 criticizes the extension as 'creating a nest of troubles'.

⁷ Although not much has been written about this defence by the English writers, it is used interchangeably however, with *volenti non fit iniuria* as a defence. See Winfield and Jolowicz (1969) 688. The writers recognize the defence in stating: "*If the circumstances warrant the inference that the plaintiff has voluntarily assumed the risk of the defendant's negligence he cannot sue.*" See also Brazier (1993) 80ff. The writer draws a distinction between *volenti non fit iniuria* and assumption of risk as a defence when he states: "*Whilst volenti non fit iniuria includes consent to an invasion of a specific interest assumption of risk includes a willingness on the part of the plaintiff to run the risk of injury from a particular source of danger.*"

⁸ The term 'assumption of risk' has also been used interchangeably with the doctrine of '*volenti non fit iniuria*' in American law. See Page and Keeton *Prosser and Keeton on the Law of Torts* (1984) 480; See also Keeton "Assumption of Risk in Products Liability Cases" 1961, 22 *LA.L.REV.* 122. The writer classifies assumption of risk into no less than six different categories namely: express, subjectively consensual, objectively consensual, by consent to conduct or condition, associational, and imposed. See further Bohlen "Voluntary Assumption of Risk" 1968 20 *Harv.L.Rev* 14 91; Wade "The Place of Assumption of Risk in the Law of Negligence" 1961 22 *LA.L.REV.* 5; Green "Assumed risk as a defence" 1961 *LA.L.REV.* 77.

where the agreement is against public interest or public policy.

The doctrine of assumption of risk, as will be seen from this Chapter, is recognised in America as a fully fledged defence, provided it is shown that the plaintiff was made aware of the risk present and the plaintiff fully understood the nature of the risk, and notwithstanding, the plaintiff freely and voluntarily chose to incur the risk. But, notwithstanding the requirements as stated hereinbefore being present, there are instances in the United States of America in which the defendant will not escape liability. Factors which militate against the recognition of the defence "assumption of risk" under the aforementioned circumstances include, where the defendant is under a public duty or a legal duty, in terms of a statute, to exercise a duty of care, one party is at such disadvantage in bargaining power, the effect of which, is to put the one party at the mercy of the other party's negligence and that the former party is allowed to contract out of his/her own negligence in breach of his/her duty of care in respect of the latter party.

Whether a deceased breadwinner's voluntary assumption of risk, that caused his/her death, can validly be raised as a defence to an action by his/her dependants seems to be fairly settled. Although this has sparked off fierce debate in the past, especially, in the South African jurisdiction, the position seems to be that, as the dependants have an independent, non-derivative right, defences such as waiver of action or voluntary assumption of risk, which would have negates the breadwinner's claim for injuries had he/she lived, will not avail against the dependants. Therefore, despite the deceased breadwinner's consent, the dependant's claim for loss of support is unaffected. Another reason for the limitation of such a defence is founded on the premise that, constitutionally, a basic duty exists that a parent, guardian or ward etc, should at all time act in the minor's best interests.⁹

In England the position seems to be regulated by statute, namely, the Unfair Contract

⁹ See Boberg (1984) 732. The writer opines that: "*whilst it would no doubt be proper to consent on the minor's behalf to a reasonable risk involved in useful vocational training, or subject him to surgery for the sake of his health or (probably) appearance, it is submitted that consent to harm or its risk without corresponding benefit is an abuse of the guardian's authority and hence ineffective.*" This, according to Boberg (1984) 732 740, accords with public policy and the principle of reasonableness. For that reason, consent is regarded as ineffective where it is *contra bonos mores*. Likewise in order to qualify in terms of the *volenti* doctrine consent can only be given to conduct reasonable under the circumstances. In this regard Boberg (1984) 732 gives an example where: "*..... if the guardian's consent took the form of a pre-accident contractual waiver (e.g. tacit acceptance of a 'patient's ride at their own risk' clause), the minor child could surely escape it cannot be prejudiced by an unreasonable consent given improperly on his behalf.*" The above stated is, it is submitted, in line with Section 28(2) of the 1996 Constitution Act 108 of 1996 which provides: "*28(2) a child's best interest is of paramount importance in every matter concerning the child.*" This foretasted principle was laid down in the South African courts as long ago as 1908 in the case of *Jameson's Minors v CSAR* 1908 TS 575 and followed consistently in other dicta, the last of which, albeit obiter appeared in the more recent case of *The Johannesburg Country Club v Stott and May NO* 2004 (5) SA (SCA).

Terms Act 1977, which enables dependants to claim successfully for loss of support despite the parents, guardian or ward assuming the risk of harm. The dependants therefore retain their autonomous and non-derivative claim. Although not regulated by statute, the common law position in America is similar to South Africa, in that, dependants retain their autonomous and non-derivative claim.

But the defences of *volenti non fit iniuria* and voluntary assumption of risks have not been restricted to general application outside the medical terrain.

What has emerged over a period of time is for hospitals to make use of consent forms, in admission procedures, wherein, the hospitals insert exculpatory clauses, couched in different wording, in an attempt at exculpating themselves from any liability, whatever form negligence takes.

The exculpatory clauses, also known as indemnity clauses or waivers of liability, are then, ultimately, used as a defence by the defendant against the plaintiff in order to escape liability.

In this Chapter it will also become clear that the defence of *volent non fit injuriae*, as a ground of justification for medical interventions, is recognised, by the legal writers and the courts alike, in the South African and English jurisdictions. The American jurisdiction prefers the doctrine of "assumption of risk" as a defence. The recognition of the defence stems from the contractual relationship between the doctor/hospital/healthcare provider and the patient, in which the consent of the patient plays a fundamental roll. The absence of consent from the patient himself/herself, or someone acting on the patient's behalf, has the effect that the medical intervention is wrongful or unlawful, unless some form of justification is present. The legal consequences that flow there-from are, the medical practitioner/hospital/healthcare provider may be criminally prosecuted for assault and/or face civil action for damages.

The presence of consent, on the other hand, has the effect that an act, which is *prima facie* actionable, deprives the plaintiff of the right afterwards to complain of it. The maxim applicable, in such cases, is known as *volenti non fit iniuria*.

But, as with the application of the defence in general terms, in a medical context, the maxim *volenti non fit iniuria* may only be raised successfully as a defence if it is shown, *inter alia*: that the patient did have sufficient knowledge of the procedure to be followed; the patient appreciated the consequences and nevertheless, consented thereto; the consent given must be recognised by law. That is, it must conform to the dictates of society, the

so-called *boni mores*.

In the so-called "contracting out of liability" cases involving medical practitioners, the South African legal writers are divided on the legal consequences. Those who are ardent followers of the doctrine of freedom of contract hold the view that the effect of these agreements is; the contract is valid. They caution that contractants should not afterwards be heard to complain against their own folly. They rely heavily on the doctrine of *caveat subscriptor* - 'let the buyer beware'. The other camp of legal writers persuasively argues that although the consent by the patient may clearly be established, nonetheless, those circumstances can only protect the medical practitioner against a claim of assault. Any attempt by a medical practitioner/hospital to contract out of liability for malpractice, ought to be declared void as against public policy, leaving the patient's right to sue for damages unimpaired.¹⁰

The writers, in this regard, contend that no medical practitioner/hospital should be released from his/her/its obligation to show due skill and care, for such conduct would be grossly unprofessional and void as against public policy. Other factors influencing their thinking include: the unequal bargaining position the patient occupies in relation to, especially, the medical practitioner, the latter occupying a position of trust; the fiduciary relationship between the medical practitioner and the patient; the influence of normative ethics and other ethical codes; medico-legal considerations and constitutional demands.

But, despite an overwhelming opinion by South African legal writers, the Supreme Court of Appeal nonetheless, in the case of *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 SCA decided, contrary to popular opinion, that through exculpatory agreements hospitals can relieve themselves from liability. As this issue forms the core of the research undertaken in this thesis, an in-depth and comprehensive discussion will follow in Chapter 14.

With regard to the English legal position, this Chapter will also carry a discussion of the doctrine of *volenti non fit iniuria* as a defence mechanism in the medical context. Although

¹⁰ Gordon Turner and Price (1953) 153ff 188ff; *Contra* Van Oosten *Encyclopaedia* (1996) 88 who holds 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 null and void." Whether or not a clause excluding liability for gross medical negligence will be upheld is according to Van Oosten "..... at least open to doubt." See also Strauss (1991) 305; Claassen and Verschoor (1992) 102-103; Burchell and Schaffer (1977) *Businessman's Law* 109-15. *Contra* Cronje-Retief (2000) 440-41 who holds the view that with regard to hospitals making use of exemption clauses "..... big institutions, corporations or other groups with unrestricted financial resources and adequate insurance exempt themselves from liability of such contracts, are effectively *contra bonos mores*, against public policy and or public interest and should be declared invalid by our courts." See further the instructive writings of Carstens and Pearmain (2007) 458ff.

the doctrine of *volenti non fit iniuria* is recognised as a defence in a medical context, certain requirements must first be met before a defendant will be successful in raising the defence. The requirements, as in South Africa, include, sufficient information must be given, by the medical practitioner, regarding the nature and scope of the medical treatment, to the patient, for the patient to form an understanding thereof. Should the patient have knowledge and sufficient understanding of the consequences, and notwithstanding, consents to the treatment, the defendant will have reasonable prospects of succeeding with the defence. But, the defence is not unlimited. Regardless of consent being given by the patient, certain legislative restrictions place a limitation on contractual freedom. In terms of the Unfair Contract Terms Act of 1977, a medical practitioner/hospital is not free to exclude or restrict his/her/its liability for death or personal injury resulting from negligence.

In this Chapter it will be seen that, in the United States of America, some legal writers recognise the doctrine of *volenti non fit iniuria* as a fundamental principle of the common law. With reference to the recognition of the defence against medical negligence however, most writers prefer the defence of assumption of risk. Consequently, the defence in a medical context will be discussed in this Chapter under the defence of voluntary assumption of risk.

Assumption of risk as a defence, in a medical context, as will be seen from the discourse in this Chapter, has received very scant attention from South African legal writers and the courts. The legal position appears, it is submitted, to be: societal dictates demand that in exercising his/her profession, the medical practitioner ought not to be allowed to compromise the degree of care and skill expected of the medical practitioner. The same is applied to hospitals and other healthcare providers. A relaxation thereof would lead to a negation of recognised medical norms and ethics.¹¹

This Chapter also sets out the English position. English legal writers, and their courts, lay

¹¹ Strauss and Strydom (1967) 320-321. The writers rely upon the trust position of the medical practitioner and the patient in which the medical practitioner through his/her expert knowledge dominates the relationship. The patient is dependent upon the medical practitioner's judgement and conduct. Societal dictates demand that in exercising his/her profession, the medical practitioner ought not be allowed to relax the degree of care and skill expected of him/her as a practitioner, notwithstanding, the patient consenting thereto. To allow that so the authors argue would be tantamount to giving the patient the authority to license the practitioner to deviate from recognised medical norms and ethics. This clearly would be against public policy or the so-called *boni mores*. See also the instructive writings of Carstens and Pearmain (2007) 458ff who state that healthcare professionals are ethically obliged by their professional rules to take due and proper care and exercise their professions with diligence was used by the Supreme Court of Appeal to justify the presence of such a clause, when it should have been used to strike it down. They go on to say "*the professional rules and standards which are applied to health professionals are an indication of what it means to be a professional in the first place. Members of the public expect to be treated in a professional manner and up to a certain standard when they seek out the service of a registered professional because if they did not, they might as well go to Joe Public for the same services.*"

down similar requirements. But the defence will not succeed, even though all the requirements have been met, where statutory restrictions are placed on the conduct of the parties, for example, the Unfair Contract Terms Act 1977, which prohibits the exclusion of liability for death or personal injury caused by negligence. The same principle is advocated when a physician and patient have reached an express agreement that the patient will voluntarily assume the risk of harm.

In a medical context, the doctrine of “assumption of risk”, in America, blends into the issue of informed consent and waiver of liability. Assumption of risk, in this context, as will be seen in this Chapter, operates in this way; the patient consents to treatment and/or surgery, notwithstanding acquiring the knowledge and understanding of possible harmful consequences, which the treatment and/or surgery may hold for him/her. But, it has been stated quite frequently by the American legal writers, that the defence of assumption of risk will be unsuccessful, despite the patient's consent, where the physician's diagnosis or treatment fall below the expected standard of due care and skill. It follows, therefore, that should the physician advise the patient of the risks and then provide improper care, the physician cannot successfully invoke the defence on the ground that the patient had assumed the risk. Waivers of liability and other attempts at exculpating medical practitioners/hospitals/healthcare providers from liability, as with assumption of risk and negligence, have been treated with disdain by the American legal writers and the courts in that, ‘contracting out of negligence’ is treated as void, against public interests or *contra bonos mores* in the United States of America.

7.2 Limiting or Excluding Liability as a Ground of Justification in general

7.2.1 The Doctrine of *volenti non fit iniuria* in general

7.2.1.1 SOUTH AFRICA

7.2.1.1.1 Legal Writings

The maxim “*volenti non fit iniuria*”, is recognised by our legal writers as a ground for justification which excludes the wrongfulness of a defendant's conduct, in circumstances in which the plaintiff's legally protected interests may be adversely affected through consent.

¹² Several definitions have been given by our legal writers to the maxim. ¹³

¹² See McKerron (1971) 67 who recognizes the application of the maxim in “cases where a person has consented to run the risk of unintentional harm, which would otherwise be actionable as attributable to the negligence of the person who causes it.” The author goes on to use the following example namely: “Consent to run the risk of being hurt as a participant in, or as a spectator at, a football or cricket match, or a motor racing meeting.” Joubert et al *The Law of South Africa* (1995) Para 89 acknowledges the justification of the maxim as a defence in our law of delict as “a ground of justification (which) excludes the wrongfulness of the defendant's conduct. It indicates conclusively that interference with the plaintiff's legally protected interests was reasonable, and therefore lawful in the circumstances.” Recognition of this maxim are also given by other legal writers including Van der Merwe and Olivier (1989) 89; Van der Walt (1979) 51. The author states that although recognised in South Africa, the

The rationale underlying the recognition of this maxim is strongly based on individualism, in which, the individual is left to work out his/ own destiny and the courts are not concerned with protecting him or her, from his/her own folly, in permitting others to do him/her harm.¹⁴

South African Law generally classifies the maxim "*volenti non fit iniuria*" into two forms, namely, in its narrower form; it takes the form of consent to a specific harm,¹⁵ whereas in its wider form it takes the form of an assumption of risk of harm.¹⁶

defence is today applied with "*greater caution and circumspection.*" See further Van Oosten (1989) 13 ff; Strauss (1961) 48 ff 63 74 286 332 ff; Burchell, Milton and Burchell *South African Criminal Law and Procedure* Vol. 1 (1997) 369; Boberg (1984) 724; De Wet *Strafreg* (1985) 94; Snyman *Strafreg* (1986) 131-132; Neethling Potgieter and Visser (2001) 82-83; Strauss and Strydom (1967) 317; Strauss (1991) 323; Carstens and Pearman (2007) 875.

¹³ See McKerron (1971) 67 who formulates the maxim as "*no man can complain of an act which he has expressly or impliedly assented to.*" See also the definition of Van der Walt and Midgley (1997) 68 who formulates the maxim as "*an injury is not done to one who consents.*" The definition of Boberg (1984) 724 and Hutchinson et al (1991) 662 are couched in similar terms namely "*a willing person is not wronged.*" *Contra* Joubert *The Law of South Africa* (1995) 112 who formulates the meaning of the maxim in the following broad terms namely: "*A person who willingly consent to the defendant's act, in the form of either a specific harmful act or an activity involving a risk of harm, cannot complain that a delict has been committed against him.*" For a similar definition see Van der Walt (1979) 50; See also Carstens and Pearman (2007) 875.

¹⁴ McKerron (1971) 67 cautions that "*no man can complain of an act which he has expressly or impliedly assented to*" or simply put by Boberg (1984) 724 "*a willing person is not wronged.*" See also Hutchinson et al (1991) 662; See further Van der Walt and Midgley (1997) 112-113 who recognize an individual's right to self-determination in stating: "*A person who willingly consents to the defendant's act, in the form of either a specific harmful act or an activity involving a risk of harm, cannot complain that a delict has been committed against him or her.*" See also Strauss and Strydom (1967) 182. Although the writers acknowledge that the maxim is founded in individualism, in a society, in which the freedom of the individual is valued and in which it is respected that each individual is entitled to work out his own destiny, nevertheless, the maxim is subject to reservations and restrictions. See Gordon et al (1953) 188 who acknowledge that whilst the individual in terms of the maxim has a freedom of choice to "*consent to an act prima facie wrongful and cannot afterwards complain of it*", nonetheless limitations are placed in certain instances, for example in the so-called "contracting out" of liability cases.

¹⁵ Strauss *Toestemming tot Benadeling* (1961) 48ff 63 74 286 332ff equates consent to "*a specific harm to assumption of the risk of harm*"; See also Van Oosten - *Informed Consent* (1989) 14. Van Oosten supports Strauss's opinion that "*without eventual harm, there can be no question of delictual liability.*" *Contra* McKerron (1971) 67ff. The writer does not relate the defence to any specific event of delict, but simply deals with it under 'general defences'. See further Loubser in the *Law of South Africa* (1995) 8 (ed Joubert) Par 79; Van der Walt and Midgley (1997) 89; Boberg (1984) 724; Van der Merwe and Olivier (1985) 89; 96-97; Neethling et al (2001) 82-83; Snyman (1986) 131-132; Visser and Vorster *General Principles of Criminal Law through the Cases* (1987) 186. For examples illustrating its functions in the narrower form, see Boberg (1984) 724. The writer notes "*the participation in a contact sport or the performance of a surgical operation*" as typical examples of the narrower form. See also Strauss (1961) 7; McKerron (1971) 67; Neethling Potgieter and Visser (2001) 883; Van der Walt (1979) 51; Van Oosten *Informed Consent* (1989) 14.

¹⁶ For an illustration of the maxim, in the wider form, see Strauss - *Toestemming tot Benadeling* (1961) 50. The writer identifies "*consent to possible risks of side-effects after an operation*" as an example of the wider form of consent; See also Neethling et al (1989) 883; See further Van Oosten *Informed Consent* (1989). The writer expresses the view that the term voluntary assumption of risk, sometimes also denote contributory intention, which, likewise, constitutes a complete defence (by excluding the alleged wrongdoings fault), or contributory

But, regardless of whatever form it takes, it remains a ground for justification which excludes the unlawfulness or wrongfulness element of a crime¹⁷ or delict.¹⁸

For consent to operate successfully as a defence, certain requirements must first be satisfied, *inter alia*, consent must be free and voluntary; the person who consents must be capable in law 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 consent given must be clear and unequivocally; its use must be recognised by law, and not be regarded as *contra bonos mores*.¹⁹

It is especially the latter requirement which is of great significance to the central theme of the investigation into the validity of exclusionary clauses in hospital contracts.²⁰

negligence, which affects the apportionment of damages.

¹⁷ Van Oosten *Informed Consent* (1989) 15. The writer holds the view that: "*Since a crime primarily constitutes a violation of the community's interests, consent does not ordinarily justify criminal conduct, which renders the application or the defence rather more limited in criminal law than in the law of delict.*" See also McKerron (1971) 73; Burchell Milton and Burchell (1983) 369; Snyman (1986) 131; Visser and Vorster (1987) 186.

¹⁸ Van Oosten *Informed Consent* (1989) 15 who states that: "*volenti non fit injuriae (unlike in the case of a pactum de non pretend in anticipando does not necessarily turn upon a wrongful act, nor is it founded upon an agreement, contract, negotiation or 'bargain' between the parties, although they have the same effect.*" See also Strauss *Toestemming tot Benadeling* (1961) 64ff. The writer also holds the view that voluntary assumption of risk must be distinguished from a specific agreement in terms of which, a person who may have a claim for damages in future, abandons that claim, i.e. the so-called 'agreement not to sue' or *pactum de non petendo in anticipando*. Strauss *Toestemming tot Benadeling* (1961) 64 on the other hand states although such an agreement is sometimes established in terms of the *volenti* doctrine; it still does not constitute assumption of risk. See also Van der Walt and Midgley (1997) 95, Joubert (1995) Vol. 8 Par.69; Van der Walt (1979) 51; Van der Merwe and Olivier (1985) 101; Neethling et al (2001) 90; *Contra* Boberg (1989) 734.

¹⁹ See the comprehensive discussion on all the requirements by Van Oosten *The Doctrine of Informed Consent* (1989) 17ff; Strauss *Toestemming tot Benadeling* (1961) 8ff; Neethling et al (2001) 98; Van der Merwe and Olivier (1989) 93ff; Van der Walt (1979) 51ff; Van der Walt and Midgley (1997) 68ff; Joubert *The Law of South Africa* (1995) 8 Par.89; Snyman (1986) 133; See further Carstens and Pearmain (2007) 883ff. The National Health Act 61 of 2003 lays down legislative requirements that need to be adhered to and against which a physician's conduct is assessed.

²⁰ Van der Walt (1979) 53-54 advocates for restrictions to be placed on 'consent to or assumption of a risk' in instances where as a result of "*the prevailing legal convictions of the community with regard to the lawfulness of the particular conduct in question*" it is considered that such consent is invalid and *contra bonos mores*. Factors which often sway the legal convictions of the community comprise the nature and extent of the interest involved the motives of the parties and the social purpose of the consent or assumption of risk. See also Gordon et al (1953) 188-189 who regard the so-called 'contracting out of liability cases' as another factor which influence societal convictions. In this regard the writers hold the view that: "*No practitioner would include in such a contract a term releasing him from any legal obligation to show due skill and care, for such conduct would be grossly unprofessional and deserving of disciplinary action by the Medical Council. But even if a practitioner did purport to contract out of liability for malpractice, it may be considered at least probable 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*

From the foregoing it is clear that, generally, our writers, in accepting the maxim “*volenti non fit iniuria*”, indicate their willingness to recognize the individual's freedom of will and capacity to regulate, unilaterally, his/her rights. Put differently, generally, the freedom of the individual is valued and respected.

But, as was stated earlier, the application of the maxim is not without reservations or restrictions. Put differently, individual freedom in certain instances is curtailed.

What is of paramount importance in medical practise is the requirement that, where a patient consents to medical treatment or surgery, no lawful consent will be obtained unless the consenting party knows and appreciates the nature, scope, consequences, rights, dangers and complications which the proposed treatment or medical intervention may bring, and, he/she appreciates what it is that he or she consents to. The requirement is better known, in medical circles, today as informed consent by the patient.²¹

Where the doctor, however, treats a patient, or performs an operation on the patient, without first obtaining the patient's consent, the doctor may be sued successfully for an assault on the patient based on negligence.²²

7.2.1.1.2 Case Law

The maxim “*volenti non fit iniuria*” has its roots firmly embedded in the South African Case Law. The application of the maxim as a defence can be traced back to 1877, when in the case of *Steel v Pearmain*,²³ the court was asked to decide whether the defendant was liable for an injury sustained by the plaintiff during participation in sport. The court held:

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.” For a similar approach see Van Oosten Encyclopaedia (1996) 88; Claassen and Verschoor (1992) 102-103; Strauss and Strydom (1967) 324-325. See further Van der Merwe and Olivier (1989) 92-93; Van der Walt and Midgley (1997) 69; Joubert *Law of South Africa* Vol 8 (1995) 116-117; Boberg (1984) 729; Strauss Toestemming tot Benadeling (1961) 8-9 416; Van Oosten The Doctrine of Informed Consent (1989) 17; Snyman (1986) 131-132; Neethling et al (2001) 89; Carstens and Pearman (2007) 468 instructively argue that there are certain obligations which should be inescapable as expressed by the *boni mores*. Such situations arrive especially where the bargaining power of the contracting parties is so unequal.

²¹ For the detailed discussion see Chapter 4 pages supra. See also Van Oosten "Informed Consent" (1989) 11-69; See also Van Oosten Encyclopaedia (1996) 67-70; Van Oosten "Castell v De Greef and The Doctrine of Informed Consent: Medical Paternalism ousted in favour of Patient Autonomy" 1995 *De Jure* 164ff; See further Boberg (1984) 751; Neethling et al (2001) 98ff; Strauss (1991) 14ff; Strauss "Bodily Injury and the Defence of Consent" 1964 *SALJ* 179; Strauss 1987 *TSAR* 1.

²² See Boberg (1984) 751; Neethling et al (2001) 94ff; Strauss (1991) 324; Van Oosten "Informed Consent" (1989) 56ff; Van Oosten (1995) *De Jure* 166.

²³ 1877 NLR 22.

*"Accidental injuries suffered in sport or by one taking part therein, at the hands of another also taking part therein, even though caused by want of skill, are not set down to culpa and are not actionable. Steel v Pearmain 1877 22."*²⁴

In a subsequent case of *Spires v Scheepers*²⁵ in which the defendant was sued for damages arising from an attack, by his ostrich, upon the plaintiff. The court held that the defendant was not liable for the attack by his ostrich, upon the plaintiff, because the plaintiff had accepted the risk.

The maxim also formed the basis of the defence of the defendant in the case of *Davids v Mendelsohn*,²⁶ in which the plaintiff sought damages arising from a roof collapsing incident. The defendant, relying on the maxim, averred that the plaintiff, a tenant, was *a volens* to risk of the roof collapsing on her whilst she remained on the premises, whilst the roof was being repaired. The court held: *"She knew the risk she was incurring by remaining in the house while the repairs were being executed, and she preferred the risk to the inconvenience of going elsewhere."* And further: *"..... but the injury was occasioned by her own fault in remaining on the premises with full knowledge of the danger and after being warned to go. If ever there was a case to which the maxim of the English law, volenti non fit iniuria, would apply, this is one."*²⁷

Although the courts at first did not extend the application of the maxim to cases where a statutory duty was breached, this however, became a recognised principle in the case of *Morrison v Anglo Deep Gold Mines Ltd.*²⁸

The facts of this case can briefly be stated as follows: The employees entered into an agreement with the employer. The contract provided, *inter alia*, that the employer, in consideration of insuring his servant against injuries caused by the negligence of a fellow-workman, shall be free from liability in respect of such interests. The question to be determined was whether it was legal for an employer to limit his liability for injury caused to a servant by the negligence of fellow-workmen. Innes CJ in his judgement recognised the maxim *volenti non fit iniuria* when he stated: *"Now it is a general principle that a man*

²⁴ *Steel v Pearmain* 1877 NLR 22.

²⁵ 1883 EDC 173.

²⁶ 1898 15 SC 367.

²⁷ *Davids v Mendelsohn* 1898 15 SC 367.

²⁸ 1905 TS 775.

contracting without duress, without fraud, and understanding what he does, may freely waive any of his rights." Innes C.J. however, cautioned that in certain instances the law recognized some acts as vitiating voluntary consent. One of those is the giving of consent must be contrary to public policy. Innes C.J. goes on to state: *"There are certain exceptions to that rule, and certainly the law will not recognise any arrangement which is contrary to public policy. That is a principle of the Roman-Dutch as well as of the English law, and it seems to me that it must be common to every system of jurisprudence."*

In considering whether it was against public policy to limit the liability of the company, in respect of the consequences of a breach of the mining regulations, the court, referring to *Griffiths v Earl of Dudley* 9 QBD 357 in which it was held that: *"..... the doctrine volenti non fit iniuria did not apply where there was a breach of statutory regulations."*

Innes C.J. concludes:

"The general rule is that any person may waive rights conferred by law solely for his benefit. Cuilibet licet renuntiare jure pro se introducto. But where public as well as individual interests are concerned, where public policy requires the observance of a statute, then the benefit of its provisions cannot be waived by the individual, because he is not the only person interested. Where a duty is imposed by common law, the result of its non-observance may be waived by the person interested unless public policy prevents his so doing. I cannot see that the same rule should not apply where the liability arises from the neglect of a duty imposed by statute."

Mason J concurring added the following:

"That claim for compensation is the private right of the man himself. He may compromise it or abandon it, when once it has arisen."

Commencing on the principle in the so-called "contracting out" of liability cases, Mason J commented as follows:

"It may be fairly argued that it is against public policy to allow a man to contract out of liability for injury done to persons by those in his employment and that argument, so far as I understand it, raises two grounds: first, that the permission to contract out may make employers careless of the safety of their servants, so that such permission is against public interest, and the second is the ground given in the American decision quoted during the argument, that it would fill the land with disabled and impoverished workmen."

The court continues:

"Now in our law it is a principle that agreements contra bonos mores will not be enforced, and that is in reality the same as the English maxim as to contracts against public policy. It is a wide reading and not well defined principle, and the courts always recognise the difficulties and dangers of the doctrine. For this argument to succeed on the ground of public policy it must be shown that the arrangement necessarily contravenes or tends to induce contravention of some fundamental principle of justice or of general or statutory law, or that it is necessarily to the prejudice of the interests of the public."

Mason J concludes, in rejecting the American dicta, when he states, in the following terms,

that the doctrine *volenti non fit iniuria* ought to be available, even where there has been a breach of statutory regulations, provided the agreement is not contrary to public policy:

"Personally I am unable to appreciate the reasons why, if a man is held to waive by conduct a claim for compensation under the common law in regard to a dancer which may prove most fatal in character, he cannot waive by express agreement this claim in the case of some trifling breach of regulations by which he may get some trifling scratch." ²⁹

The recognition of the doctrine of *volenti non fit iniuria* also received the attention of the court in the case of *Waring & Gillow Ltd v Sherborne*. ³⁰ Not only did the court recognise the maxim, Innes C.J. also laid down certain criteria which had to be met before a litigant could successfully utilize the maxim *volenti non fit iniuria* as a defence.

For the first time the essential elements of knowledge, appreciation and prevailing consent were realized as main criteria. In this regard Innes C.J. stated:

"The maxim volenti non fit iniuria embodies a principle which, when confined within right limits, is both just and equitable. A man who consents to suffer an injury can as a general rule have no right to complain. He who, knowing and realizing a danger, voluntarily agrees to undergo it, has only himself to thank for the consequences. But like so many other maxima, the one under consideration needs to be employed cautiously and with circumspection. The principle is clear, the difficulty lies in the application of it, in deciding, in other words, under the circumstances of each particular case whether the injured man was volens to undertake the risk. A consideration of the grounds upon which the doctrine rests, and of the cases in which its scope has been discussed, leads to the conclusion that in order to render the maxim applicable, it must be clearly shown that the risk was known, that it was realised, and that it was voluntarily undertaken. Knowledge, appreciation, consent - these are the essential elements." ³¹

Other matters in which the South African courts have pronounced on the validity of the maxim, "*volenti non fit iniuria*", as a defence, include *Lampert v Hefer NO* ³² in which the court stated:

"These are the defences of volenti non fit iniuria and contributory negligence respectively; I merely quote two passages taken at random for it is trite law that our system recognizes both defences." ³³

In considering voluntary assumption of risk as a defence, the court concluded that there are many instances in which voluntary assumption of risk and *volenti non fit iniuria*, as

²⁹ *Morrison v Anglo Deep Gold Mines Ltd* 1905 TS 775.

³⁰ 1904 TS 340.

³¹ 1955 (2) SA 507 (A).

³² *Lampert v Hefer NO* 1955 (2) SA 507 (A). This was the start of what Boberg (1984) 724 call the start of "grafting another limb on to the *volenti* principle and which has since been a nest of troubles."

³³ *Lampert v Hefer N.O.* 1955 (2) SA 507 (A).

defences, overlap.

This was also the approach by the Appellate Division (as it was known then) in the case of *Santam Insurance Co Ltd v Vorster*³⁴ in which Ogilvie Thompson CJ held at 774:

"The rule that no injury is committed against one who consents is as old as Digest 47.10.15. In modern times this rule is conveniently and more usually expressed by the maxim volenti non fit iniuria. The defence indicated by the maxim is undoubtedly recognized in our law. The maxim comprehends a wide field. In its simplest forms of which express consent to a surgical operation or the tacit consent of participants in a contact sport such as rugby, football afford clear illustrations - the defence gives rise to little or no difficulty. In practise it is the application of this volens defence in what are conveniently known as 'risk' cases which presents problems. In such cases the defence is variously designated the 'voluntary assumption', 'voluntary acceptance' or 'voluntary encountering' of risk, or risk of injury..... "

The effect of the defence of the maxim *volenti non fit iniuria* is put as follows by Ogilvie Thompson CJ:

"There exists a considerable weight of authority to the effect that, if established, the volens defence eliminates any duty of care, or as some writers prefer to put it, negatives the commission of any actionable unlawful act, and, consequently, that it would operate entirely to exclude any claim by dependants (see e.g. McKerron op cit 70-3, Strauss 'Aspekte' (); Van der Merwe & Olivier op cit 95, 135; Schwietering op cit 144; and cf. also Salmon Torts 15 ed 665, and Walker The Law of Delict of Scotland 1966 ed vol. II 731) Contrary views are however not entirely lacking (see Macintosh & Stand op cit 62ff, and Price (1949) 66, SALJ 269 at 271-3 and (1952) 15 THRHR 68 at 80). Bearing in mind the peculiar nature of the dependant's action in our law. I express no opinion on this controversy, and wish to record that nothing in this judgement should be regarded as leaving the position of a possible claim by dependants anything but open; for future decision as when it should arise." ³⁵

Our courts have also recognised the requirement, namely, in order to succeed with a defence of *volenti non fit iniuria*, or voluntary assumption of risk, as a ground of justification, the consent to or assumption of risk must not be considered *contra bonos moros*. In determining whether consent is *contra bonos mores*, the courts will consider the prevailing legal convictions of the community with regard to the lawfulness of the particular conduct.

Our courts as far back as 1904, in the case of *Morrison v Anglo Deep Gold Mines Ltd*,³⁶ recognised that, despite a person's autonomy and freedom of will to do on certain conduct, there are, notwithstanding, *"..... Certain exceptions to that rule, and certainly the law will not recognize any arrangement which is contrary to public policy."*

In the case of *Morrison*, the court weighed up several factors in determining whether the

³⁴ 1973 (4) SA (A).

³⁵ *Santam Insurance Co Ltd v Vorster* 1973 (4) SA 764 (A) at 777.

³⁶ 1905 TS 775.

arrangement was contrary to public policy, *inter alia* "... the observance of a statute which affects not only the individual, but other members of a statute affecting the safety of the workforce may make employers careless of the safety of their servants." ³⁷

In the case of *Santam Insurance Co Ltd v Vorster* ³⁸ the court considered the "reprehensibility" of the "dicing" consent as a factor. Citing two English decisions the court stated:

"I agree with the observation of Lord Bramwell (in Smith v Baker & Sons (1891) AC 325 (HL)) which was cited with approval by Davis J in the National Meat Supplies v Spittal at 505, that a man may be volens to encounter the natural dangers of a business but not those superadded by negligence'." ³⁹

In *S v Collett* ⁴⁰ the court considered whether a defence of consent, arising from an agreement by a servant, that his master may inflict corporal punishment upon him, was a valid and recognized defence, the court rejected the defence. Relying on the following factors namely, "the infliction of corporal punishment by a master on his servant being contrary to public policy" and "the unequal bargaining of the servant when concluding the agreement". The court held:

"In truth, it seems to us that the infliction of corporal punishment by a master on his servant is clearly contrary to public policy and bonos mores. In the relationship of master and servant the role of the master is, of course, a dominant one and that of the servant is a subservient one. Even in the field of contract it has been long recognised that public policy requires that he be protected from the disadvantageous consequences of agreements which he may have felt obliged to enter into with his master, the reason being that as a servant he is not contracting on equal terms with his master."

Subsequently in rejecting the defence the court concluded:

"It is to our minds quite inconceivable that public policy would ever permit a master to circumvent the ordinary process of the law in the way the appellant did in this case, or permit a servant to make a valid election to allow the master to do so rather than subject himself to the ordinary process of the law. The process of the law is there not only to punish the guilty but for the protection of an accused person and he is not permitted to consent to the withdrawal of that protection even though he personally may prefer to be dealt with summarily by his master rather than face a possible prison sentence at the hands of the court. To hold otherwise could lead to the undermining of the whole fabric of criminal justice." ⁴¹

7.2.1.1.3 Legal Opinion

³⁷ *Morrison v Anglo Deep Gold Mines Ltd* 1905 TS 775.

³⁸ 1973 (3) SA 764 (A) at (782).

³⁹ *Santam Insurance Co Ltd v Vorster* 1973 (4) SA 764 (A).

⁴⁰ 1978 (3) SA 206 (R AD).

⁴¹ *S v Collett* 1978 (3) SA 206 (RAD).

- (1) The doctrine of *volenti non fit iniuria* is recognised in South Africa, by both our legal writers as well as our courts.⁴²
- (2) The maxim *volenti non fit iniuria* is recognised as a ground of justification which excludes the wrongfulness of a defendant's conduct in circumstances in which the plaintiff's legally protected interests may be adversely affected through consent.⁴³
- (3) The rationale for the recognition of this defence is very much based on individualism or private autonomy in which the individual is left to work out his/her own destiny.⁴⁴
- (4) The effect of the maxim, as a ground of justification, lies in the fact that it excludes the unlawfulness or wrongfulness element of a crime or delict.⁴⁵

⁴² Strauss *Toestemming tot Benadeling* An unpublished doctoral thesis (1961) 3-6; McKerron *The Law of Delict* (1971) 67; Joubert et al *The Law of South Africa* (1995) Volume 8 Par 112; Van der Merwe and Olivier *Die Onregmatige Daad in die Suid-Afrikaanse Reg* (1989) 89; Van der Walt *Delict: Principles and Cases* (1979) 51; Van Oosten *The Doctrine of Informed Consent* An unpublished doctoral thesis (1989) 13ff; Burchell, Milton and Burchell *South African Criminal Law and Procedure* Volume 1 (1983) 369; Boberg *The Law of Delict* (1984) 724; De Wet *Strafreg* (1985) 94; Snyman *Strafreg* (1986) 131-132; Neethling et al *Deliktereg* (1989) 82-83; Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 317; Strauss *Doctor Patient and the Law* (1991) 323. Carstens and Pearman *Foundational Principles of South African Medical Law* (2007) 875ff. For case law see *Steel v Pearman* 1877 NLR 22; *Spines v Scheepers* 1883 EDL 173; *Davids v Mendelson* 1898 15 SC 361; *Morrison v Anglo Deep Gold Mines Ltd* 1905 TS 775; *Waring & Gillon Ltd v Sherborne* 1904 TS 340; *Lampert v Hefer NO* 1955 (2) SA 507 (A); *Santam Insurance Co Ltd v Vorster* 1973 (4) SA (A); *S v Collett* 1978 (3) SA 206 (RAD).

⁴³ Strauss *Toestemming tot Benadeling* An unpublished doctoral thesis (1961) 3-6; McKerron *The Law of Delict* (1971) 67; Joubert et al *The Law of South Africa* (1995) Volume 8 Par 112; Van der Merwe and Olivier *Die Onregmatige Daad in die Suid-Afrikaanse Reg* (1989) 89; Van der Walt *Delict: Principles and Cases* (1979) 51; Van Oosten *The Doctrine of Informed Consent* An unpublished doctoral thesis (1989) 13ff; Burchell, Milton and Burchell *South African Criminal Law and Procedures* Volume 1 (1983) 369; Boberg *The Law of Delict* (1984) 724; De Wet *Strafreg* (1985) 94; Snyman *Strafreg* (1986) 131-132; Neethling et al *Deliktereg* (1989) 82-83; Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 317; Strauss *Doctor Patient and The Law* (1991) 323. Carstens and Pearman *Foundational Principles of South African Medical Law* (2007) 875ff. For case law see *Steel v Pearman* 1877 NLR 22; *Spines v Scheepers* 1883 EDL 173; *Davids v Mendelson* 1898 15 SC 361; *Morrison v Anglo Deep Gold Mines Ltd* 1905 TS 775; *Waring & Gillon Ltd v Sherborne* 1904 TS 340; *Lampert v Hefer NO* 1955 (2) SA 507 (A); *Santam Insurance Co Ltd v Vorster* 1973 (4) SA (A); *S v Collett* 1978 (3) SA 206 (RAD).

⁴⁴ McKerron *The Law of Delict* (1971) 67; Boberg *The Law of Delict* (1984) 724; Hutchinson et al Wille's *Principles of South African Law* (1991) 662; Van der Walt and Midgley *Delict: Principles and Cases* (1997) 112-113; Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 182 as well as Gordon et al *Medical Jurisprudence* (1953) 188 whilst acknowledging that the maxim is founded in individualism, nevertheless, limitations and restrictions are placed in certain instances for example in the so-called 'contracting of liability cases. The maxim is thus not unlimited. For case law see *Morrison v Anglo Deep Gold Mines Ltd* 1905 TS 775.

⁴⁵ Van Oosten *The Doctrine of Informed Consent* An unpublished doctoral theses (1989) 15; McKerron *The Law of Delict* (1971) 73; Burchell Milton and Burchell *South African Criminal Law and Procedure* Volume 1 (1983) 369; Snyman *Strafreg* (1986) 131-132; Visser and Vorster *General Principles of Criminal Law* through the cases (1987) 186; Strauss *Toestemming tot Benadeling* An unpublished doctoral thesis (1961) 64ff; Van der Walt and Midgley *Delict: Principles and Cases* (1997) 95; Joubert *Lawsa* 1995 Vol 8 Par 69; Van der Walt *Delict: Principles and Cases* (1979) 51; Van der Merwe and Olivier *Die Onregmatige Daad in die Suid-Afrikaanse Reg* (1915) 101.

- (5) Consent is a fundamental element of the maxim *volenti non fit iniuria*. For consent to operate successfully as a defence, certain requirements must first be satisfied, *inter alia*, the consenting party must have had knowledge and been aware of the nature and extent of the harm or risk; its use must be recognised by law, and not be regarded as *contra bonos mores*.⁴⁶
- (6) There is broad consensus amongst our legal writers that restrictions ought to be placed in certain circumstances on consent to or assumption of risk especially in the so-called 'contracting out of liability cases'.⁴⁷

7.2.1.2 ENGLAND

7.2.1.2.1 Legal Writings

One of the defences available in English law to a defendant which serves as a justification for a wrongful act resulting in damages, is that of *volenti non fit iniuria*.⁴⁸ The maxim *volenti non fit iniuria* was first recognized in the works of the classical Roman jurists and first recognized in English law A.D.1250-1258.⁴⁹

A prerequisite for the success of the maxim *volenti non fit iniuria* is the plaintiff's consent. Consent as a defence takes two forms, namely, *volenti non fit iniuria*, in which the plaintiff

⁴⁶ Van Oosten *The Doctrine of Informed Consent* An unpublished doctoral theses (1989) 17ff; Strauss *Toestemming tot Benadeling* An unpublished doctoral thesis (1961) 8ff; Neethling et al *Deliktereg* (1989) 78; Van der Merwe and Olivier *Die Onregmatige Daad in die Suid-Afrikaanse Reg* (1989) 93ff; Van der Walt *Delict Principles and Cases* (1979) 51ff; Van der Walt and Midgley *Delict: Principles and Cases* (1997) 68ff; Joubert *The Law of South Africa* (1995) Vol 8 Par 89; Snyman *Strafreg* (1986) 133. Carstens and Pearman *Foundational Principles of South African Medical Law* (2007) 876ff. For case law see *Morrison v Anglo Deep Gold Mines Ltd* 1905 TS 775.

⁴⁷ See Van der Walt *Delict: Principles and Cases* (1979) 53-54. The writers ascribe the restrictions placed on consent in certain instances due to the prevailing legal convictions of the community. See also Gordon et al *Medical Jurisprudence* (1953) 188-189 who is especially critical of the so-called 'contracting out of liability cases.' According to the writers the inclusion of a clause in a contract releasing a practitioner from any legal obligation to show due skill and care would be grossly unprofessional. Courts should regard those contracts as void as against public policy. For a similar view see Van Oosten *Encyclopaedia* (1986) 88; Claassen and Verschoor *Medical Negligence* (1992) 102-103; Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg*; Van der Merwe and Olivier *Die Onregmatige Daad in die Suid-Afrikaanse Reg* (1989) 92-93; Van der Walt and Midgley *Delict: Principles and Cases* (1997) 69; Joubert *The Law of South Africa* Vol 8 (1995) 116-117; Boberg *The Law of Delict* (1984) 729. Carstens and Pearman *Foundational Principles of South African Medical Law* (2007) 468ff. For case law see the case of *Morrison v Anglo Deep Gold Mines Ltd* 1905 TS 775.

⁴⁸ See Winfield and Jolowicz *Tort* (1989) 682. The writers recognizes the justification for the defence of *volenti non fit iniuria* in that a person who would otherwise have had a remedy in tort would now be deprived " because he consented, or at least assented, to the doing of the act which caused his harm."

⁴⁹ See Been *Journal of Comparative Legislation* (1907) 185; See also DIG. 47, 10, 1, 5; See, too DIG. 9.2.7.4: 50. 17,203; See further Bracton *De Legibus Anglia* 1250-1258 A.D.

consents to an invasion of his interest which would otherwise be a tort (conveniently called consent), and, assumption of risk, which signifies a willingness on the part of the plaintiff to run the risk of injury from a particular source of danger.⁵⁰

In English law, consent may be given expressly, by words, or be inferred from conduct.⁵¹ Before consent may be invoked successfully as a defence, it must be shown that consent was freely given,⁵² that the plaintiff must have knowledge of the risk⁵³ and be warned thereof by the defendant.⁵⁴

In consenting to the risk of injury, it has been made clear by the writers Winfield & Jolowicz, that, in so doing, the plaintiff does not necessarily consent to negligence⁵⁵ nor does he consent to an illegal act or agreement which is against public policy.⁵⁶

It has been suggested before that, although certain English statutes, such as the Occupier's Liability Act 1957 and 1984, recognize the *volenti non fit iniuria* doctrine and provide that the defence of *volenti* may apply in appropriate circumstances, the Unfair Contract Terms Act 1977 outlaws clauses excluding or limiting liability for negligence or breach of an occupier's duty of care resulting in death or personal injuries, and those excluding or limiting liability for other types of harm, unless it is reasonable in all the circumstances to do so.⁵⁷

⁵⁰ Winfield and Jolowicz (1989) 682-683; See also Street (1993) 80.

⁵¹ Winfield and Jolowicz (1989) 683 uses the examples of a fair blow in a boxing match, an inoculation or holding out one's arm for an injection to demonstrate consent in this regard. See also Street (1993) 80-81.

⁵² See Winfield and Jolowicz (1989) 691. According to the writers "*a man cannot be said to be truly willing unless he is in a position to choose freely.*" The writers adds a caveat namely: "*.... freedom of choice predicates, not only full knowledge of the circumstances on which the exercise of choice is conditional, so that he may be able to choose wisely, but the absence of any feeling of constraint so that nothing shall interfere with the freedom of his will.*"

⁵³ Winfield and Jolowicz (1989) 690.

⁵⁴ Winfield and Jolowicz (1989) 691.

⁵⁵ Winfield and Jolowicz (1989) 691.

⁵⁶ Winfield and Jolowicz (1989) 692-693. The writers hold the view that a contravention of a rule designed only to produce fair play for example should not automatically amount to negligence. For that reason the writers opine that in accepting certain risks it does not necessarily entail the elimination of all duty of care. A spectator does not therefore "*.... consent to negligence on the part of the participants*" and "*.... provided the competition or game is being performed within the rules and requirement of the sport and by a person of adequate skill or competence the spectator does not expect his safety to be regarded by the participant.*"

⁵⁷ See Winfield and Jolowicz (1989) 686-687 where for example two parties enter into a contract which entails an express exclusion of liability. The question according to the writers ought not to be whether the plaintiff did in fact agree to run the risk of negligence, but whether the defendant had given sufficient motive to make the excluding

7.2.1.2.2 Case Law

Although the requirements for the defence of *volenti non fit iniuria* in a negligence action have long been a subject which has raised some controversy, what has emerged from the earliest cases is that it must be shown that the plaintiff acted voluntarily, and that he exercised a general freedom of choice. One of the first decided cases on this point arose in the case of *Smith v Baker*,⁵⁸ in which the plaintiff was employed by the defendants on the construction of a railway. While he was working, a crane moved rocks over his head. Both he and his employers knew there was a risk of a stone falling on him and he had complained to them about this. A stone fell and injured the plaintiff and he sued his employers for negligence. The employers pleaded *volenti non fit iniuria* but this was rejected by the court.

The court subsequently held: "*Although the plaintiff knew of the risk and continued to work, there was no evidence that he had voluntarily undertaken to run the risk of injury. Merely continuing to work did not indicate volens.*"⁵⁹

The plaintiff's genuine freedom of choice, before the defence can be successfully raised against him, also formed the subject of a decision in *Bowater v Rowley Regis Corporation*,⁶⁰ in which Scott LJ stated that: "*A man cannot be said to be truly willing unless he is in a position to choose freely, and freedom of choice predicates, not only full knowledge of the*

term part of the contract. The writers opine that in such event "... the plaintiff was bound even though he might not have troubled to read the terms and hence was unaware of the excluding one." *Contra* the Unfair Contract Terms Act 1977 which provides: "Where the defendant acts in the course of a business or occupies premises for business purposes he cannot, by reference to any contract term or notice, exclude or restrict his liability for death or personal injury resulting from negligence, and in the case of other loss or damage caused by negligence can only exclude or restrict his liability in so far as the term in the contract or notice is reasonable. See 55 2(1); 2(2); 2(3) of the Act. It is also provided "where a contract term or a notice purports to exclude or restrict. The implication of the provisions of the Unfair Contract Terms Act according to Winfield and Jolowicz (1989) 687 "is that the defence of *volenti non fit iniuria* is still available, but it remains to be seen what evidence of voluntary acceptance of the risk beyond the making of the agreement (which is not enough) will be required." See Harpwood *Principles of Tort Law* (1998) 391. The writer recognizes that the influence of the legislation in preventing the use of exclusion clauses stem from the changing of attitudes of the courts and later of parliament towards the issue of consent. According to Harpwood (1998) 391: "This picture first emerged in relation to contractual situations in which it was acknowledged that consumers and employees have little or no control over the terms of the agreements into which they enter. The courts developed the role, by convoluted means, frequently twisting and turning in order to circumvent unfair contractual provisions of protecting consumers. This approach spilled over into the law of tort and is part of a wider movement towards greater emphasis affording protection to the weaker party in many situations."

⁵⁸ (1891) AC 325.

⁵⁹ *Smith v Baker* (1891) AC 325.

⁶⁰ (1944) KB 476.

circumstances on which the exercise of choice is conditioned, so that he may be able to choose wisely, but the absence from his mind of any feeling of constraint so that nothing shall interfere with the freedom of his will " ⁶¹

A further requirement which must be complied with, before a defendant may succeed with a defence of *volenti non fit iniuria* in a negligent action, is for the defendant to show that at the time the plaintiff consented, the plaintiff had full knowledge of the nature and extent of the risk that he ran. This aspect received the attention of the court in the case of *Wooldridge v Summer*. ⁶² The facts can be stated briefly as follows:

The plaintiff was a professional photographer. During a horse show he positioned himself at the edge of the arena. He was knocked down and injured by a horse when the rider lost control while riding too fast. The plaintiff subsequently sued the defendant for damages. The defendant in return raised the defence of *volenti non fit iniuria*.

Diplock LJ laid down fundamental principles required before the defence of *volenti non fit iniuria* will succeed as a defence. In this regard the judge stated:

"A person attending a game or competition takes the risk of any damage caused to him by any act of a participant done in the course of and for the purposes of the game or competition, notwithstanding that such an act may involve an error of judgement or lapse of skill, unless the participants conduct is such as to evince a reckless disregard of the spectator's safety.

The spectator takes the risk because such an act involves no breach of his duty of care owed by the participant to him. He does not take the risk by virtue of the doctrine expressed or obscured by the maxim volenti non fit iniuria. The maxim states a principle of estoppel applicable originally to a Roman citizen who consented to being sold as a slave. Although pleaded and argued below, it was only faintly relied on by counsel for the first defendant in this court. In my view, the maxim, in the absence of express contract, has no application to negligence simpliciter where the duty of care is based solely on proximity or 'neighbourship' in the Atkinian sense. The maxim in English law presupposes a tortious act by the defendant. The consent that is relevant is not consent to the risk of injury, but consent to the lack of reasonable care that may produce that risk and requires on the part of the plaintiff at the time at which he gives his consent full knowledge of the nature and extent of the risk that he ran. In Dann v Hamilton, Asquith J expressed doubts whether the maxim ever could apply to license in advance a subsequent act of negligence, for if the consent precedes the act of negligence, the plaintiff cannot at the time have full knowledge of the extent as well as the nature of the risk which he will run." ⁶³

7.2.1.2.3 Legal Opinion

(1) The maxim *volenti non fit iniuria* is recognised in England, by both legal writers as

⁶¹ *Bowater v Rowley Regis Corporation* (1944) KB 476.

⁶² (1963) 2 QB 43.

⁶³ *Wooldridge v Summer* (1963) 2 QB 43.

well as the courts, as a fully fledged defence.⁶⁴

- (2) *Volenti non fit iniuria* as a defence serves as a justification for a wrongful act resulting in damages.⁶⁵
- (3) A prerequisite for the success of the maxim is the plaintiff's consent, provided, consent, *inter alia*, is given freely, the plaintiff has knowledge of the risk, and nevertheless, consents thereto and, provided further, the act consented to is not an illegal act nor is the agreement entered into against public policy.⁶⁶
- (4) In England, The Unfair Contract Terms Act 1977 prohibits clauses which are aimed at excluding or limiting liability for negligence or breach of a duty of care resulting in death or personal injuries.⁶⁷

7.2.1.3 UNITED STATES OF AMERICA

7.2.1.3.1 Legal Writings

Volenti non fit iniuria is regarded as a fundamental principle of the American Common Law.⁶⁸ Its importance lies in the fact that the maxim *volenti non fit iniuria* has as its foundation consent to an act which is *prima facie* actionable and which deprives the plaintiff of the right afterwards to complain of it.⁶⁹ The rationale for the existence of the maxim, *volenti non fit iniuria*, is founded in the non-paternalistic view held by the American legal writers. Their attitude is generally, where no public interest is contravened, the individual is left to work out his own destiny, and they are not concerned with protecting him from his own folly in permitting others to do him harm.⁷⁰

⁶⁴ See Winfield and Jolowicz *Tort* (1989) 682; Street *Torts* (1993) 80. For English case law see the early decision of *Smith v Baker* (1891) AC 325; *Bowater v Newley Regis Corporation* (1944) KB 476; *Wooldridge v Summer* (1963) 2 QB 43.

⁶⁵ See Winfield and Jolowicz *Tort* (1989) 682; Street *Torts* (1993) 80. For English case law see the early decision of *Smith v Baker* (1891) AC 325; *Bowater v Newley Regis Corporation* (1944) KB 476; *Wooldridge v Summer* (1963) 2 QB 43.

⁶⁶ Winfield and Jolowicz (1989) 690-693.

⁶⁷ SB 2(1); 2(2); 2(3) of the Unfair Contract Terms of Act 1977.

⁶⁸ See Page and Keeton *Prosser and Keeton on the Law of Torts* (1984) 112. The author translates the maxim as "..... to one who is willing, no wrong is done."

⁶⁹ Gordon et al (1953) 153.

⁷⁰ See Page and Keeton *Prosser and Keeton on the Law of Torts* (1984) 112; See also Bohlen, "Consent as Affecting Civil Liability for Breaches of the Peace" (1924) 24 *COL.L.REV.* 819.

The maxim built around the *volenti* principle, is known in the American law, as is the position in English law, and received into South African law as "consent".⁷¹ The effect of consent is thus, where a plaintiff's interests have been invaded, the fact that he consents, negates the wrongful event of the defendant's act, and prevents the existence of a tort.⁷²

Consent may be manifested by words or conduct. In the former situation, the plaintiff expressly says, for example, "*it's all right with me*", in which event he will have difficulty in denying that he did consent. In the latter situation, he/she, for example, holds up his arm without objecting to be vaccinated.

Likewise, he will not be heard to deny that he has consented after the defendant has relied upon his action. In instances where the plaintiff attempts to deny that he consented through conduct, actual willingness may be established by competent evidence in which the test of how would the reasonable man interpret the conduct.⁷³

Examples most generally used amongst American legal writers to depict the maxim, *volenti non fit iniuria*, can be found in those who enter into a sport, game or contest, may be taken to consent to physical contacts consistent with the understood rules of the game.⁷⁴ For consent to be effective, and in so doing, escape liability, certain requirements first have to be met. Where the requirements are not met, consent may be regarded as ineffective. According to Prosser and Keeton, consent of a person on whom an otherwise actionable invasion is inflicted is ineffective if:

"(1) Such person lacked capacity to consent to the conduct, (2) the consent was coerced, (3) the consenting person was mistaken about the nature and quality of the invasion intended by the conduct, or (4) the conduct was the kind of conduct to which no one can give a valid consent so as to avoid liability."

It is especially points (3) and (4) which needs a brief elucidation. The American writers are generally in agreement that, where a plaintiff assents to the conduct, while mistaken about the nature and quality of the invasion intended by the defendant, the plaintiff cannot ordinarily be regarded as actually consenting to the defendant's conduct, hence, the

⁷¹ See Strauss *Toestemming tot Benadeling* (1961) 5-6; See also Bohlen *Consent as Affecting Civil Liability* (1924) 46.

⁷² See Page and Keeton *Prosser and Keeton on the Law of Torts* (1984) 112.

⁷³ See Page and Keeton *Prosser and Keeton on the Law of Torts* (1984) 113.

⁷⁴ See Page and Keeton *Prosser and Keeton on the Law of Torts* (1984) 114.

defendant will not succeed in his defence of *volenti non fit iniuria*.⁷⁵ Thus, a woman who consents to intercourse may still successfully sue for damages when she finds that she has been a victim of a mock marriage. Therefore, the fact that the consent was procured by a promise to marry, which the defendant did not intend to honour, would not vitiate the consent.⁷⁶

Likewise, in cases involving medical or surgical treatment, where the defendant is aware that the patient does not understand the nature of the operation, or the risk of undesirable consequences involved therein, but, notwithstanding, continue with the medical or surgical treatment, the defendant's conduct will vitiate consent and the defendant may very well be liable to the plaintiff for damages founded on battery.⁷⁷

The same prevails according to *Prosser and Keeton*⁷⁸ in instances where 'active misrepresentation' occurs as well as in instances where there has been 'a non-disclosure' of consequences which the surgeon knew to be certain to follow.

7.2.1.3.2 Case Law

In one of the very first American cases involving consent, in a vaccinating case in which the plaintiff sued the defendant, in tort, for an assault based on the fact that she did not consent, the Supreme Court of Massachusetts in *O'Brien v Cunard S.S. Co*⁷⁹ was confronted with two questions namely: First, whether there was any evidence to warrant the jury in finding that the defendant by way of its servants or agents, committed an assault on the plaintiff; Secondly, whether there was evidence on which the jury could have found that the defendant was guilty of negligence towards the plaintiff. The plaintiff relied on the fact that the surgeon who was employed by the defendant vaccinated her on board a ship, while she was on her passage from Queenstown to Boston. In determining whether she consented, the court was guided by her overt acts and manifestations of her feelings. The evidence in this regard was that at Boston, at the time, there were strict quarantine

⁷⁵ See Page and Keeton *Prosser and Keeton on the Law of Torts* (1984) 119. The writers holds the view that "if the defendant knew, or probably ought to have known in the exercise of reasonable care, that the plaintiff was mistaken as to the nature and quality of the invasion intended, likewise an overt manifestation of assent or willingness would not be effective apparent consent."

⁷⁶ See Page and Keeton *Prosser and Keeton on the Law of Torts* (1984) 120.

⁷⁷ See Page and Keeton *Prosser and Keeton on the Law of Torts* (1984) 120.

⁷⁸ See Page and Keeton *Prosser and Keeton on the Law of Torts* (1984) 120.

⁷⁹ 1891 154 MASS. 272, 28 N.E. 266.

regulations in place. All immigrants were expected to be protected from small-pox by vaccination. Only those persons who held a certificate from the medical officer of the steamship were permitted to land. It appears that with the vaccination incident the plaintiff was one of the hundred women gathered on a deck. On her own version she understood from conversation that they were being vaccinated. She could also clearly see that the surgeon "examined" their arms, and then vaccinating them. Upon her turn, she showed him her arm and he examined her but besides saying "there is no mark and she needs to be vaccinated" he said nothing. After she held up her arm to be vaccinated, he vaccinated her and she took the ticket and left. According to the surgeon's evidence there was nothing to the contrary to show that she did not want to be vaccinated. The court subsequently confirmed that, having viewed her conduct in the light of the surrounding circumstances, there was nothing to indicate that the surgeon's conduct was not lawful; the court also answered the negligence question in the negative.

In the case of *De May v Roberts*,⁸⁰ the Supreme Court of Michigan dealt with an unusual set of facts involving consent in which the defendant, (in court a quo) a physician, was sued for breach of privacy. The evidence revealed that on a dark and stormy night, the physician was called out to medically attend to the plaintiff (in court a quo). The physician being sick and very fatigued from overwork, asked one Scatterwood, an unprofessional, to accompany him to the patient's home. Scatterwood was assigned to assist him in carrying a lantern, umbrella and certain articles deemed necessary on such occasions. Upon arrival, the defendant introduced Scatterwood to the husband as a friend who was accompanying him. Scatterwood accompanied the defendant to the room where they found the plaintiff. Scatterwood remained present throughout the examination and treatment. In fact, the defendant requested him to hold her hand during a paroxysm of pain. Neither the plaintiff nor her husband knew the true character of Scatterwood. The plaintiff claimed that the occasion was a most sacred one and no one had a right to intrude unless invited or because of some real and pressing necessity.

The court subsequently confirmed the court a quo's judgement against the defendant. The court found the plaintiff had a legal right to privacy of her apartment at such a time. The law required that others had to observe this and to abstain from its violation. The fact that, at the time she consented to the presence of Scatterwood, supposing him to be a physician does not preclude her from maintaining an action and incurring substantial damages, upon afterwards ascertaining his true character. The court also held that in obtaining admission at

⁸⁰ 1881 46 MICH 160, 9. N.W. 146.

such time, under such circumstances, without fully disclosing his true character, both parties were guilty of deceit.

In the case of *Hart v Geysel*,⁸¹ which involves an action brought by the Administrator of the estate of the deceased, who died as the result of a blow received in a prize fight, the court had to decide whether the deceased's consent precluded a successful claim from the opponent prize-fighter. The court subsequently held that "there are no facts which show anger, malicious intent to injure, or excessive force." Therefore the court held: *"..... one who engages in prize fighting, even though prohibited by positive law, and sustains an injury, should not have a right to recover any damages that he may sustain as the result of the combat, which he expressly consented to and engaged in as a matter of business or sport."*⁸²

In other medical cases, where consent is given tacitly, by the patient, for medical examinations or treatment and the defendant are sued afterwards see *Baxter v Snow*.⁸³

"Where, as in this case, a patient who finds difficulty in hearing goes to a physician to ascertain the cause and voluntarily submits to treatment by that physician with full knowledge of what that physician is doing, and acquiesces and consents to all that the physician does, he clearly by implication authorises the physician to diagnose the case, to discover for himself the cause of his patient's disability, and to give such treatment as in the judgement of the physician is reasonably necessary. Although the patient may have believed that his disability was due to an accumulation of wax in his ear, that belief on his part did not relieve the physician of the obligation to discover the true cause of the disability that he was called on to remedy. Where one has voluntarily submitted himself to a physician for diagnosis and treatment, it will be presumed, in the absence of evidence to the contrary, that what the physician did was either expressly or by implication authorised."

The afore stated case should be contrasted with that of *McLeish v Cohen*,⁸⁴ where the court was confronted with a significant conflict of evidence as to whether the plaintiff had demanded that the defendant should extract certain teeth, or whether she had simply submitted herself to dental treatment. The Maryland Court of Appeals stated:

"If a patient goes to a dentist or a physician and submits herself for diagnosis, with the request, express or implied, that he do what is necessary to give her relief, then he is answerable only for the lack of proper knowledge, skill, and care in the treatment or operation. In this case it was a question of fact for the jury whether Mrs Cohen went to the dentist because she was suffering pain from her teeth generally, and submitted herself to his judgement, or whether she went to him to have two roots extracted from the upper jaw and he, in violation of her instructions and without her consent, pulled two lower teeth instead. If Mrs Cohen engaged the defendants to

⁸¹ 1930 159 WASH 632, 294 P.570.

⁸² *Hart v Geysel* 1930 159 WASH. 632, 294 P.570.

⁸³ (UTAH) 2 PAL (2d) 257, 1931 - 35 M.L.C. 241.

⁸⁴ (MD) 148 ATL. 124; 1926 - 30 M.L.C. 1190.

extract certain teeth indicated by her, her consent before extracting any others was necessary. The contradictory statements of dentist, and patient as to what was said and done made it proper for the trial Court to submit the case to the jury."

In the case of *Marsh v Colby*,⁸⁵ involving trespass for fishing on plaintiff's land, the common court of Michigan held that as; "it has always been customary, however, to permit the public to take fish in all the small lakes and ponds of the state, and in the absence of any notification to the contrary, we think anyone may understand that he is licensed to do so. No such notification appears in this case, and we therefore hold that the defendant was not trespassing upon plaintiff's land with the intent to take fish, having no knowledge that objection existed to his doing so."

7.2.1.3.2 Legal Opinion

- (1) The United States of America has adopted a similar position as England and South Africa in recognising the maxim *volenti non fit iniuria* as a defence.⁸⁶
- (2) The maxim *volenti non fit iniuria* has as its foundation consent to an act which is *prima facie* actionable and which deprives the plaintiff of the right, afterwards, to complain of it.⁸⁷
- (3) The rationale for the existence of the maxim *volenti non fit iniuria* is founded in the philosophical view held by the legal writers. In this respect, individual freedom triumphs over paternalism.⁸⁸
- (4) The effect of consent, in this context, is that it negates the wrongful event of the defendant's act and deprives the plaintiff of a civil claim afterwards.⁸⁹
- (5) For consent to be effective certain requirements have to be met, inter *alia*, the

⁸⁵ 1878 39 MICH. 626.

⁸⁶ Page and Keeton *Prosser and Keeton The Law of Torts* (1984) 112. For the American case law, see *O'Brien v Cunard S.S. Co* (1891) 154 MASS. 272, 28 N.E. 266; *De May v Roberts* (1881) 46 MICH.160, 9 N.W. 146; *Hart v Geysel* (1930) 159 WASH.632, 294, 570; *McClees v Cohen* (MD) 148 at 124, 1926 30 MLC 1190; *Marsh v Colby* 1878 39 MICH. 626.

⁸⁷ Page and Keeton *Prosser and Keeton The Law of Torts* (1984) 112. For the American case law, see *O'Brien v Cunard S.S. Co* (1891) 154 MASS. 272, 28 N.E. 266; *De May v Roberts* (1881) 46 MICH. 160, 9 N.W. 146; *Hart v Geysel* (1930) 159 WASH. 632, 294, 570; *McClees v Cohen* (MD) 148 at 124, 1926 30 MLC 1190; *Marsh v Colby* 1878 39 MICH. 626.

⁸⁸ Page and Keeton *Prosser and Keeton The Law of Tort* (1984) 112; Bohlen "Consent as Affecting Civil Liability for Breaches of the Peace" (1924) 24 *Columbia Law Review* 819.

⁸⁹ Page and Keeton *Prosser and Keeton The Law of Tort* (1984) 112.

consenting party must be made aware and be aware of the invasion intended by the conduct. In other words, the consenting party must be aware of the risk and of the consequences.⁹⁰

7.2.2 Assumption of Risk in General Context

7.2.2.1 SOUTH AFRICA

7.2.2.1.1 Legal Writings

The term 'voluntary assumption of risk' is a term widely used by our writers.⁹¹ Some of the writers have expressed the view that the term 'voluntary assumption of risk' is an extension of the doctrine '*volenti non fit iniuria*', in that it takes the wider form.⁹² It is also clear from our legal writers, that whatever form the maxim *volenti non fit iniuria* takes and whether 'voluntary assumption of risk' is regarded as an extension of the said maxim or regarded as a separate defence all together, they take two distinct forms. Whereas *volenti non fit iniuria* involves consent to a specific harmful act of the defendant, voluntary assumption of risk involves the assumption of the risk of harm connected with the activity of the defendant.

In order to succeed with a defence of voluntary assumption of risk, the defendant is required to show that the plaintiff had knowledge of the risk of harm, that the plaintiff appreciated the nature and extent of the risk involved and, notwithstanding, the plaintiff freely and voluntarily assumed the risk.⁹³

⁹⁰ Page and Keeton *Prosser and Keeton The Law of Tort* (1984) 114 ff.

⁹¹ See Strauss *Toestemming tot Benadeling* (1961) 50. The writer expresses the view that this situation occurs in practice mainly in sport and medical operations. In sport for example when a player takes part in a rugby match he is well aware of the risk of injuries he may suffer arising from the contact with opponents. In a medical context it is general practice that the doctor brings to the patient's attention that there is a risk that side-effects may flow from an operation to be undertaken by the doctor or surgeon. This notwithstanding, the patient nevertheless consents to the operation. See also Van Oosten *The Doctrine of Informed Consent* (1989) 14; McKerron (1971) 70; Van der Walt (1979) 51ff; Van der Walt and Midgley (1997) 69; Joubert *The Law of South Africa* Volume 8 (1995) Par 89; Hutchison et al (1991) 662; Boberg (1984) 724ff; Neethling et al (1989) 83. The term 'voluntary assumption of risk' is generally used by the writers referred to above. The writers Strauss *Toestemming tot Benadeling* (1961) 57ff 60ff 64ff; McKerron (1971) 70; Van der Merwe and Olivier (1989) 101; Van der Walt (1979) 55; Boberg (1984) 725ff 729 prefer the term 'consent to the risk of harm' instead of 'voluntary assumption of risk' on account of their reasoning that the latter denotes complacently whereas the former specifically denotes consent.

⁹² See Van Oosten (1989) 14; Van der Walt (1979) 51; McKerron (1971) 67; Van der Walt and Midgley (1997) 68; Joubert *LAWSA* Volume 8 (1995) Par 89; *Contra* Van der Merwe and Olivier (1989) 96.

⁹³ See Joubert *LAWSA* Volume 8 (1995) Par 79; See also Van der Walt (1979) 57; See further McKerron (1971) 67. The writer uses the examples of consent to undergo a surgical operation on the one hand as opposed to consenting to take the risk where for example a spectator attends a cricket match. See further Van der Walt and Midgley (1997) 68ff; Hutchinson et al (1991) 662; Van der Merwe and Olivier (1984) 89 96-97; Strauss *Toestemming tot Benadeling* (1961) 49ff.

In a medical context, the defence of voluntary assumption of risk may successfully be pleaded, provided the defendant shows that the patient was informed of the seriousness or likely risks attendant upon treatment or the operation, that the patient fully appreciated the 'seriousness' or likely risks involved and, notwithstanding, freely and voluntarily consented thereto.⁹⁴

7.2.2.1.2 Case Law

The defence of voluntary assumption of risk received the attention of the South African courts as far back as 1904. In the case of *Waring & Gillon, Ltd v Sherborne*,⁹⁵ the court laid down clearly defined criteria in order to establish the defence of voluntary assumption of risk. The court stated that "... knowledge, appreciation, and consent - these are the essential elements" The court continues:

"Now where a man voluntarily, deliberately, and with full knowledge continues in an employment to the very nature of which grave risks are incidental, it may be comparatively easy to come to a conclusion as to whether he consented to take the chance of these risks. But the difficulty of the inquiry is very much greater when the danger which affects him has been suddenly created or increased by the negligence of his employer, and is a danger not necessarily arising from the nature of his work. To quote the words of Lord Hershell (Smith v Baker & Sons (1891) AC 325 at 362): "Where there is a risk to the employed, which may or may not result in injury, has been created or enhanced by the negligence of the employer, does the mere continuance in service, with knowledge of the risk, preclude the employed, if he suffer from such negligence, from recovering in respect of his employer's breach of duty: I cannot assent to the proposition that the maxim volenti non fit iniuria to such a case, and that the employer can invoke its and to protect him from liability for his wrong." ⁹⁶

The criteria were confirmed in other non-medical cases as well. In the case of *Lampert v Hefer NO*,⁹⁷ the court indicated what evidence is to be considered in establishing whether the criteria have been met:

"Where the defence is that the plaintiff voluntarily became a passenger in a motor vehicle controlled by an intoxicated driver, the degree of intoxication may be of importance in considering whether the plaintiff either, in fact, appreciated, or was negligent in failing to appreciate, that the intoxication was such as to involve the risk of an accident." ⁹⁸

The leading South African decision on the scope of the defence of voluntary assumption of risk and, in particular the meaning of the consent element, is that of the Appellate Division

⁹⁴ See Van der Walt (1979) 51ff; Van der Merwe and Olivier (1989) 96ff; Van der Walt and Midgley (1997) 69ff; McKerron (1971) 67ff; Joubert LAWSA Vol 8 (1995) Par 89.

⁹⁵ 1904 TS 340 at 345.

⁹⁶ *Waring and Gillow, Ltd v Sherborne* 1904 TS 340; See also *Union Government v Matthee* 1917 A.D. 688, 703

⁹⁷ 1955 (2) SA 507 (A).

⁹⁸ *Lampert v Hefer NO* 1955 (2 SA 507 (A)).

(as it was known then) in *Santam Insurance Co Ltd v Vorster*:⁹⁹

*"I am accordingly of the opinion that, if it be shown that, in addition to knowledge and appreciation of the danger, the claimant foresaw the risk of injury to himself, that will ordinarily suffice to establish the "consent" required to render him volens provided always that the particular risk which culminated in his injuries falls within the ambit of the thus foreseen risk. The inherent difficulty that the central factum probandum - viz. the consent to the particular risk which occasioned the supervening injuries - is basically a subjective enquiry can, I suggest, only be bridged by way of inference from the proved facts. In the nature of things, direct evidence will seldom, if ever, be available; and manifestly the negative ipso dixit of the claimant himself can by itself usually carry but little weight. The Court must, in my view, thus perforce resort first to an objective assessment of the relevant facts in order to determine what, in the premises, may fairly be said to have been the inherent risks of the particular hazardous activity under consideration. Thereafter the Court must proceed to make a factual finding upon the vital question as to whether or not the claimant must, despite his probable protestations as to the contrary, have foreseen the particular risk which later eventuated and caused his injuries, and is accordingly held to have consented thereto."*¹⁰⁰

The case of *Boshoff v Boshoff*,¹⁰¹ illustrates the application of the test of knowledge appreciation and consent to a situation of sporting injuries. The facts of the matter can be briefly stated: The plaintiff who was playing squash, was hit by his opponent's racquet and injured. It was alleged that he knew that players could be hit by a racquet flying out of the hand of a player. It was also averred that the injured brother had appreciated this risk and consented to run the risk..... "

The court, in upholding the defence of voluntary assumption of risk, laid down the following criteria:

*"In regard to consent to sporting injuries or voluntary assumption of the risk of such injuries, the sport must be a lawful one (not for instance, duelling or Russian roulette) and the injury must occur while the defendant is acting within the broad rules of the game."*¹⁰²

In a more recent judgement in the case of *Oosthuizen v Homegas (Pty) Ltd*:¹⁰³

*"It is clear that the three essential elements of this defence are knowledge, appreciation and consent. To my mind the defence fails for the reason that plaintiff has not been proved to have had knowledge of the full extent of the danger involved in the decanting of petroleum gas and that he accordingly could not have appreciated the full extent of the danger that threatened him. That being so, it has also not been shown that he consented."*¹⁰⁴

In a number of decisions, involving medical negligence cases, the South African courts have

⁹⁹ 1973 (4) SA 764 (A).

¹⁰⁰ *Santam Insurance Co Ltd v Vorster* 1973 (9) SA 764 (A).

¹⁰¹ 1987 (2) SA 694 (O).

¹⁰² *Boshoff v Boshoff* 1987 (2) SA 694 (O).

¹⁰³ 1992 (3) SA 463 (O) at 472 G-H.

¹⁰⁴ *Oosthuizen v Homegas (Pty) Ltd* 1992 (3) SA 467 O at 472G-H.

laid down certain criteria which must be met before a doctor or surgeon may escape liability in using the defence of voluntary assumption of risk as a defence. Our courts have laid specific emphasis on the aspect of informed consent.

In a very early case of *Ex parte Dixie*¹⁰⁵ Millin 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 operation upon him which they may consider beneficial. They would only be justified in performing a major operation without consent where the operation is urgently necessary and cannot with due regard to the patient's interests be delayed."*¹⁰⁶

In the matter of *Rompel v Botha*:¹⁰⁷

*"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."*¹⁰⁸

The knowledge of harm or risk also received the attention of the court in the case of *Esterhuizen v Administrator, Transvaal*.¹⁰⁹ The court laid down the following principle:

*"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."*¹¹⁰

Although it has been held in several South African decisions that a patient must be informed of the serious or likely risks attended upon treatment or the operation, the courts

¹⁰⁵ 1950 (4) SA 748 (W) at 751.

¹⁰⁶ *Ex Parte Dixie* 1950 (4) SA 748 at 751.

¹⁰⁷ (An unreported judgement delivered in the TPD division on the 15th April 1953).

¹⁰⁸ *Rompel v Botha* (An unreported judgement delivered in the TPD on the 15th April 1953).

¹⁰⁹ 1957 (3) SA 710 (T).

¹¹⁰ *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T).

have held, however, that the medical practitioner does not have to inform the patient of the remote risks. This aspect received the courts attention in *Richter v Estate Hamman*.¹¹¹

The following approach was adopted by Watermeyer J:

*"A doctor whose advise 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 interests to have it."*¹¹²

In a more recent case of *Castell v De Greef*,¹¹³ the court balanced a patient's autonomy or right to self-determination, against the duty of the medical practitioner's right as to what disclosure is required in the circumstances. The court endorsed the approach of Scott J in the court a quo:

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

And relying on the dictum of *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T) at 719 CD in which Bekker J stated the following:

"Generally speaking to establish the defence of volenti non fit iniuria 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....."

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."

Relying heavily on the patient-orientated approach, the court continues:

"I am of the view that there is not only a justification, but indeed a necessity, for introducing a patient-orientated approach in this connection."

Approving of the defence of *volenti non fit iniuria* the court continues:

"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 iniuria which would justify an otherwise wrongful delictual act. (See, inter alia, Stoffberg v Elliott 1923 CPD 148 at 149-50; Lymbery v Jefferies 1925 AD 236 on 240; Lampert v Hefer NO 1955 (2) SA 507 (A) at 508;

¹¹¹ 1976 (3) SA 226 (C).

¹¹² *Richter v Estate Hamman* 1976 (3) SA 226 (C).

¹¹³ 1994 (4) SA 408 CPD.

Esterhuizen's case supra at 718-22; Richter's case supra at 232 and Verhoef v Meyer 1975 (TPD) and 1976 (A) (unreported), discussed in Strauss (op cit at 35-6)."

Relying then on the criteria enunciated by our writers and the courts in the past namely knowledge, appreciation of risk and especially voluntary and free consent the court stated:

*"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 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 her breast. Even if the risk of the 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."*¹¹⁴

Whether a deceased breadwinner's voluntary assumption of the risk that caused his death, can be raised as a defence to an action by his dependants has long sparked off fierce debate, often leading to controversies. On the one hand, there is the established notion that dependants have an independent, non-derivative right, so that defences which would have negated the breadwinner's claim for injuries had he lived (such as contributing negligence or waiver of action or voluntary assumption of risk) will not avail against the dependants. In this instance, it is suggested that, despite the deceased breadwinner's consent, the dependant's claim for loss of support is unaffected.¹¹⁵

On the other hand, there is another notion that the dependant's action, notwithstanding its

¹¹⁴ *Castell v De Greef* 1994 (4) 59 408 at 420-421.

¹¹⁵ For those writers who supports the notion that the deceased person's voluntary assumption of risk of fatal injury does not deprive his/her dependants of their action for the loss of his support. See N.J. Van der Merwe *Acta Juridica* (1964) 82 at 83-93; See also Van der Merwe and Olivier (1989) 348-54; A.M. Conradie (1943) 7 THRHR 133 at 149; W.A. Joubert (1958) 21 THRHR 12 at 13. See also Boberg (1984) 734 who summarizes the thinking of the other writers as: *"This is because it is wrongfulness in volens to the deceased that the consent negatives, not wrongfulness in relation to his dependants. An act may be wrongful in relation to one person but not in relation to another. Thus if the deceased's consent (or assumption of risk) negatives the wrongfulness of causing his death, as far as he is concerned, it does not necessarily (though it may - see the next paragraph) also negative the wrongfulness of simultaneously depriving his dependants of his support, as far as they are concerned. Of course, the 'traditional' view that the dependant's action rests upon a wrong (or breach of duty) to the deceased, not to the dependants, would defeat this argument."* See also the comment of W.E. Scott (1976) 9 De Jure 218 at 222 who aligns himself with especially Van der Merwe and Olivier (1989) who state: *"..... though volenti negatives wrongfulness, the breadwinner's consent does not deprive his dependants of their action: only their own consent can do that."* See also Lee and Honoré *Obligations* (1950) 599 who agrees but comments as follows: *"Although it has been suggested that volenti negatives the duty of care, the better view however is that volenti is no defence (against dependants) because even though the deceased could not have claimed damages had he lived, the dependants can, as the duty owed to them is independent of that owed to the deceased."* For further approval of the notion see Van der Walt and Midgley (1997) 72; Joubert *LAWSA* (1995) Vol 8 Par 79 state that based on public policy *"a parent or guardian cannot contractually exclude possible delictual actions by dependants in the event of his death."* See also Van der Walt (1979) 55.

non-derivative character, is based on the breach of a duty owed, at the time of the wrongful act, to the injured or the deceased. The notion is based upon the belief that once it is shown that voluntary assumption of risk took place, there is a denial that there has been any negligence. In other words; no wrong was done to the deceased. Based on that premise, the dependant's claim for loss of support falls away.¹¹⁶

Bearing the above in mind, the question may be begged, can a parent or guardian contractually exclude possible delictual actions, by a minor, in circumstances where the parent or guardian, when consenting, foresees the risk of harm?

Though a parent or guardian, as seen above, may at times be called upon to consent on behalf of minors, his power to do so cannot be unlimited, for his basic duty is to act at all times in the minor's best interests.¹¹⁷

Whether a deceased person's voluntary assumption of the risk of fatal injury deprives his/her dependants of their action for the loss of his support, has remained unresolved in our case law for decades. The long lineage of the so-called "dependant's action", in South African case law, has its origin in the well known case of *Jameson's Minors v CSAR*.¹¹⁸ In that case, a passenger travelling under a free pass was killed in a railway accident. The pass was issued to him at his own request, on the terms that he accepted all risks of injury

¹¹⁶ For the writers who supports this controversial view see McKerron 53 *SALJ* (1936) 413. See also McKerron 67 *SALJ* (1950) 62; See Walter Pollack 48 *SALJ* (1931) 191; See also Milner 72 *SALJ* (1955) 233; See also Schwietering 20 *THRHR* (1957) 138 at 144. The writer opines that with assumption of risk, as with all other defences, an action by the dependants based upon loss of support is denied as the wrongfulness is excluded. *Contra*, Price 66 *SALJ* (1949) 269. The writer holds the view that assumption of risk is "indistinguishable from the deceased's mere waiver of action, with the remedy of the dependant's is left unscathed". See also Boberg (1984) 728 who calls the afore stated notion a 'jurisprudential monstrosity' in that the "argument contains a fallacy that is easily exposed" for "if the deceased's consent justifies the infliction of harm upon him, it does not follow that it also justifies the infliction of harm upon his dependants." Boberg also expresses the view that: "*If a person's consent negatives wrongfulness, it does so only in relation to him; he is not empowered thus summarily also to dispense with the rights of his dependants.*"

¹¹⁷ Boberg (1984) 732. The writer opines that "*whilst it would no doubt be proper to consent on the minor's behalf to a reasonable risk involved in useful vocational training, or subject him to surgery for the sake of his health or (probably) appearance, it is submitted that consent to harm or its risk without corresponding benefit is an abuse of the guardian's authority and hence ineffective.*" The above principles according to Boberg 732 740 is based on public policy and the principle of reasonableness. For that reason consent is regarded as ineffective. If it is *contra bonos mores* likewise consent can only be given to conduct reasonable under the circumstances to qualify in terms of the *volenti* doctrine. In this regard Boberg 732 gives the example that: "*.... if the guardian's consent took the form of a pre-accident contractual waiver (e.g. tacit acceptance of a 'patients ride at their own risk' clause), the minor could surely escape it. cannot be prejudiced by an unreasonable consent given improperly on his behalf.*" The above stated is, it is submitted, in line with Section 28(2) of the 1996 Constitution Act 108 of 1996 which provides: "*28(2) a child's best interest is of paramount importance in every matter concerning the child.*"

¹¹⁸ 1908 TS 575.

to himself, however caused. In a subsequent rail accident the said passenger was killed. Subsequently the plaintiff's sued, in their capacity as the guardians of the three minor daughters of the late Adam Jameson. Consequently, the court was asked to decide whether the agreement entered into between the deceased and the railway administration, in which the deceased voluntarily assumed the risk of injury and waived his right to claim damages from the railway administration, was, in law, also applicable to his dependants, who sued the railway administration for loss of support? The court in considering Roman law principles stated:

*"But while on the one hand it resembles the ordinary action for personal injury in that it is based upon culpa, and while the breach of duty essential to its existence is the breach of a duty owed at the time of the wrongful act to the injured man; yet, on the other hand, the compensation claimable under it is due to third parties, who do not derive their rights through his estate, but on whom they are automatically conferred by the fact of his death. The action is one sui generis; probably its anomalous character may be accounted for by reference to its original sources; but, whatever the explanation, the fact remains that it exists quite independently, and is not in any way derived from the deceased or through his estate. (Voet, 9.2.11; Grotius, 3.32.2)"*¹¹⁹

The dependant's potential claims (especially that of minors) for loss of support notwithstanding a defence being put up, is highlighted as follows in the case of *Victor NO v Constantia Insurance Co Ltd*:¹²⁰

"A child's claim against a third party who has wrongfully caused his father's death arises not from the fact that he has lost his claim for familial support, but because he has lost his right to claim support from the deceased. It has never been suggested that a child's claim for loss of support arising from the death of his father, should be reduced because he has a right to claim support from other members of his family."

The court added:

*"Considerations of public policy do not favour the reduction of a child's claim. An adoption order is made only after careful consideration by a children's court of all the factors mentioned in s71 of the Act, one of which is that the proposed adoption will `serve the interests and conduce to the welfare of the child'. It would not be in the public interest to allow a wrongdoer to benefit from the care which others, namely the adoptive parents, through entirely altruistic and charitable motives, chose to devote to the child.... "*¹²¹

There are however decisions in which it was decided, although obiter, that the dependant's may have no action if the deceased voluntarily assumed the risk. In *Union Government (Minister of Railways & Harbours) v Matthee*¹²² the question was raised whether the doctrine of *volenti non fit iniuria* can be invoked by a defendant, in an action brought, not

¹¹⁹ *Jameson's Minors v CSAR* 1908 TS 575 at 584-5.

¹²⁰ 1985 (1) SA 118 (C).

¹²¹ *Victor NO v Constantia Insurance Co Ltd* 1985 (1) SA 118 (6) at 125.

¹²² 1917(AD) 688.

by the injured man himself, but by his dependants, in respect of damage sustained by them in consequence of his death?

Innes CJ in this regard stated:

"It remains shortly to consider a final defence pleaded at the trial, to which no reference has yet been made. It was that the deceased man knew and appreciated the risks involved in unloading the timber in question, and voluntarily consented to incur them. There is no need to decide the very interesting question whether a defence of this nature can be invoked by a defendant in an action brought not by the injured man himself by his family in respect of damage sustained by his death. Because I agree with the Provincial Division, that, even if the defence were available, it could not succeed." ¹²³

In the case of *Lampert v Hefer NO*, ¹²⁴ the court *obiter* also remarked that the dependants may have no action in the following terms:

"Certainly if an arrangement is sought which will provide due protection for what are conceived to be just claims of dependants, while at the same time doing justice to defendants, it should be designed to rest rather on whether there really was a duty owed by the defendant to the deceased and not on what form of language is used in the plea. For present purposes, however, it does not seem to me that there is any advantage in departing from the customary usage which distinguishes consent from contributory negligence and treats the voluntary assumption of risk as a form of consent." ¹²⁵

In *Evans v Shield* ¹²⁶ the court looked at the common law position regarding a dependant's action for damages for loss of the support of the breadwinner, its evolution and its nature as summarized by Holmes JA in *Legal Insurance Company Ltd v Botes* 1963 (1) SA 608 (A) at 614B-G as follows:

"The remedy was unknown to Roman law, in which no action arose out of the death of a freeman, and consequently the Aquilian action was not available. It had its origin in Germanic custom, in which the reparation of 'maaggeld' was regarded as a conciliation to obviate revenge by the kinsmen of the deceased, and it was divided among the latter's children or parents or other blood relatives. The Roman-Dutch law modified the custom by regarding the payment as compensation to the dependants for loss of maintenance. The Roman-Dutch jurists felt that this could be accommodated within the extended framework of the Roman Aquilian action by means of an utilis actio. The remedy has continued its evolution in South Africa, particularly during the course of this century, through judicial pronouncements, including judgements of this Court, and it has kept abreast of the times in regard to such matters as benefits from insurance policies. The remedy relates to material loss 'caused to the dependants of the deceased man by his death'. It aims at placing them in as good a position, as regards maintenance, as they would have been in if the deceased had not been killed. To this end, material losses as well as benefits and prospects must be considered. The remedy has been described as anomalous, peculiar, and sui generis, but it is effective."

The court then stated:

¹²³ *Union Government (Minister of Railway & Harbours) v Matthee* 1917 (AD) 688 at 703.

¹²⁴ 1955 (2) SA 507 (A) at 507.

¹²⁵ *Lampert v Hefer NO* 1955 (2) SA 507 (A) at 508.

¹²⁶ 1980 (2) SA 814 (AD)



"An essential and unusual feature of the remedy is that, while the defendant incurs liability because he has acted wrongfully and negligently (or with *dolus*) towards the deceased and thereby caused the death of the deceased, the claimant (the dependant) derives his right of action not through the deceased or from his estate but from the fact that he has been injured by the death of the deceased and that the defendant is in law responsible therefore. Only a dependant to whom the deceased was under a legal duty to provide maintenance and support may sue and in such action the dependant must establish actual patrimonial loss, accrued and prospective, as a consequence of the death of the breadwinner." ¹²⁷

In a leading Appellate Division case of *Santam Insurance Co Ltd v Vorster*, ¹²⁸ the court *obiter* also passed the following remarks regarding the exclusion of action of dependants where a defence of *volens* is raised successfully. In this regard the court stated:

"There exists a considerable weight of authority to the effect that, if established, the *volens* defence eliminates any duty of care, or, as some writers prefer to put it, negatives the commission of any actionable unlawful act, and, consequently, that it would operate entirely to exclude any claim by dependants (see e.g. *McKerron op cit* 70-3, *Strauss 'Aspekte'* 60, *Van der Merwe & Olivier op cit* 95, 135, *Schwietering op cit* 144; and cf. also *Salmond Torts* 15 ed 665, and *Walker The Law of Delict of Scotland* 1966 ed vol. II 731). Contrary views are however not entirely lacking (see *Macintosh & Scoble op cit* 62ff, and *Price (1949)* 66 SALJ 269 at 271-3, and (1952) 15 THRHR 60 at 80). Bearing in mind the peculiar nature of the dependant's action in our law, I express no opinion on this controversy, and wish to record that nothing in this judgement should be regarded as leaving the position of a possible claim by dependants anything but open for future decision as and when it should arise." ¹²⁹

In a more recent case of *The Johannesburg Country Club v Stott and May NO*, ¹³⁰ the Supreme Court of Appeal was confronted with a dependant's claim for the wife of the deceased breadwinner. The minor children were represented in so far as the deceased estate was concerned but were not involved in the current dispute. The facts of the case may be summarised as follows: The late Mr Stott was a member of the appellant, the Johannesburg Country Club. So was his wife, the respondent. While playing golf on the sixth fairway at the club, on 4 March 2000, he apparently sought shelter, under a cover of some sort, during a rainstorm. Lightning struck and he was severely injured and subsequently passed away on 24 March. Mrs Stott was seeking to hold the club liable for her loss, alleging that he had been killed as a result of the negligence of the club.

The Appellant, the Johannesburg Country Club, denied liability, relying on an exemption clause members have to sign when joining the club, in which the new member, upon signing the form, which contained the exemption clause, indemnified the club from any

¹²⁷ *Evans v Shield* 1980 (2) SA 814(A).

¹²⁸ 1973 (4) SA 764 (A).

¹²⁹ *Santam Insurance Co Ltd v Vorster* 1973 (4) SA 764 (A) at 777.

¹³⁰ 2004 (5) SA (SCA).

liability. After considering the doctrine of the exemption clause and the general rules pertaining to exemption clauses, the court was left with the question of whether the provision 'plainly' absolves the club from a dependant's claim.

Harms JA although obiter relied upon the case of *Jameson's Minors v Central South African Railways* 1908 TS 575 in stating: "..... That it was not possible for Mr Stott to exempt the club from such liability as one cannot forego the autonomous claims of dependants."

Recognizing the defence of *volenti non fit iniuria* the court stated: "... had Mr Stott survived the lightning strike, his claim for personal injuries would no doubt have been hit by this exclusion and Mrs Stott would also not have had a claim because a dependant's claim arises only upon the death of the breadwinner."

The court concluded that as the exemption clause referred to "personal harm"; the wording "personal harm" did not ordinarily refer to a dependant's claim.

The court, in criticizing the radical nature of indemnity clauses which exclude liability for damages for the negligent causing of the death of another, concluded:

"It is arguable that to permit such exclusion would be against public policy because it runs counter to the high value the common law and, now, the Constitution place on the sanctity of life." ¹³¹

7.2.2.1.3 Legal Opinion

- (1) Voluntary assumption of risk as a defence is widely recognised by our legal writers. To some it is an extension of the maxim *volenti non fit iniuria* and to others it is regarded as a separate defence all together. ¹³²
- (2) Before voluntary assumption of risk will succeed as a defence, certain requirements must first be met, inter alia, it is shown that the plaintiff had knowledge of the risk

¹³¹ *The Johannesburg Country Club v Stott and May NO* (2004) (5) SA (SCA) at 516.

¹³² Strauss *Toestemming tot Benadeling* An unpublished doctoral thesis (1961) 50; Van Oosten *The Doctrine of Informed Consent* An unpublished Doctoral Thesis (1989) 14; McKerron *The Law of Delict* (1967) 70; Van der Walt *Delict: Principles and Cases* (1979) 51 ff; Van der Walt and Midgley *Delict: Principles and Cases* (1997) 68-69; Joubert *The Law of South Africa* Vol 8 (1995) Par 89; Hutchison et al *Wille's Principles in South African Law* (1991) 662; Boberg *The Law of Delict* (1984) 724 ff; Neethling et al *Deliktereg* (1989) 83. For case law recognizing voluntary assumption of risk see *Waring & Gillon Ltd v Sherborne* 1904 TS 340 at 345; *Lampert v Hefer NO* 1955 (2) SA 507 (A); *Union Government v Matthee* 1917 AD 688 703; *Santam Insurance Co Ltd v Vorster* 1973 (4) SA 764 (A); *Boshoff v Boshoff* 1987 (2) SA 694 (O); *Oosthuizen v Homegas (Pty) Ltd* 1992 (3) SA 463 (O) at 472 G-H; For the recognition of voluntary assumption of risk in a medical context see *Ex parte Dixie* 1950 (4) SA 748 (W) at 751; *Rompel v Botha* (Unreported decision in the TPA 15 April 1953); *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T); *Richter v Estate Hamman* 1976 (3) SA 226 (C); *Castell v De Greef* 1994 (4) SA 408 CPA at 420-421.

of harm; that the plaintiff appreciated the nature and extent of the risk involved and notwithstanding, the plaintiff freely and voluntarily assumed the risk.¹³³

- (3) In a medical context, the defence of voluntary assumption of risk may successfully be pleaded, provided, the defendant shows that the patient was informed of the seriousness or likely risks attended upon the treatment or the operation and the patient fully appreciated the seriousness or likely risks involved and freely consented thereto.¹³⁴
- (4) The effect of voluntary assumption of risk as a defence is that, like with consent, it negates wrongfulness.¹³⁵
- (5) Although voluntary assumption of risk appears to correspond with that of a waiver of action, the so-called *pactum de non petendo*, must be distinguished from the assumption of risk in that a *pactum de non petendo* merely bans the remedy for harm once entered into, without, affecting the wrongfulness of the act. Voluntary assumption of risk on the other hand negates wrongfulness.¹³⁶
- (6) Whether a deceased breadwinner's voluntary assumption of the risk that caused his death, can be raised as a defence to an action by his dependants, has long been a subject of controversy.

¹³³ Joubert *The Law of South Africa* Vol 8 (1995) Par 79; Van der Walt *Delict: Principles and Cases* (1979) 57; McKerron *The Law of Delict* (1971) 67; Van der Walt and Midgley *Delict: Principles and Cases* (1997) 68ff; Hutchinson et al *Wille's Principles of South African Law* (1991) 662; Van der Merwe and Olivier *Die Onregmatige Daad in die Suid-Afrikaanse Reg* (1984) 89 96-97; Strauss *Toestemming tot Benadeling* An unpublished doctoral thesis (1961) 49ff. For case law see *Waring & Gillon Ltd v Sherborne* 1904 TS 340 at 345; *Lampert v Hefer NO* 1955 (2) SA 507 (A); *Union Government v Matthee* 1917 AD 688, 703; *Santam Insurance Co Ltd v Vorster* 1973 (4) SA 764 (A); *Boshoff v Boshoff* 1987 (2) SA 694 (O); *Oosthuizen v Homecare (Pty) Ltd* 1992 (3) SA 463 (O) 472.

¹³⁴ Van der Walt *Delict: Principles and Cases* (1979) 51ff; Van der Merwe and Olivier *Die Onregmatige Daad in die Suid-Afrikaanse Reg* (1989) 96ff; Van der Merwe and Midgley *Delict: Principles and Cases* (1997) 69ff; McKerron *The Law of Delict* (1971) 67ff; Joubert *The Law of South Africa* Vol 8 (1995) Par 89. For the relevant case law see *Ex parte Dixie* 1950 (4) SA 748; *Rompel v Botha* (Unreported judgement in the TPA Division 15 April 1953); *Esterhuizen v Administrator, Transvaal* 1958 (3) SA 710 (7); *Richter v Estate Hamman* 1976 (3) SA 226 (C); *Castell v De Greef* 1994 (4) SA 408 (CPA).

¹³⁵ Van der Walt and Midgley *Delict: Principles and Cases* (1997) 69ff; Joubert *The Law of South Africa* Volume 8 (1995) Par 89; Van Oosten *Encyclopaedia* (1996) 67ff; Strauss and Strydom *Die Suid Afrikaanse Geneeskundige Reg* (1967) 216; Claassen and Verschoor *Medical Negligence* (1992) 62ff.

¹³⁶ Boberg *The Law of Delict* (1984) 738ff; Van der Merwe and Olivier *Die Onregmatige Daad in die Suid-Afrikaanse Reg* (1989) 105-106; Van der Walt *Delict: Principles and Cases* (1979) 36.

- (7) Two schools of thought have attempted to find answers to the discourse. One school of thought advanced the argument that dependants have an independent, non-derivative right, so that defences which would have negated the breadwinner's claim for injuries had he lived (such as waiver of action or voluntary assumption of risk) will not avail against the dependants. In this instance, despite the deceased breadwinner's consent, the dependants claim for loss of support is unaffected.¹³⁷ The other school of thought advance the counter argument that once it is shown that voluntary assumption of risk took place, the dependant's claim for loss of support falls away.¹³⁸
- (8) The legal position has now been settled, by the Supreme Court of Appeal, in the case of *Johannesburg Country Club v Stott and May N.O.*¹³⁹ In this case the court held that it was not possible for a deceased person to exempt a club from liability for the claim of dependants arising from the negligent act of a defendant. The rationale for this decision is based upon the notion that, to forego the autonomous claims of dependants would be against public policy, because it runs counter to the high value the Common Law, and now, the Constitution place on the sanctity of life.

7.2.2.2 ENGLAND

7.2.2.2.1 Legal Writings

In so far as assumption of risk as a defence is concerned, not much is written about this defence by the English writers. Nevertheless, it is used inter changeably with the *volenti* maxim by the legal writers.¹⁴⁰ It is however recognised as a separate defence to that of the maxim *volenti non fit iniuria*. Before assumption of risk may be invoked with a measure of

¹³⁷ See Van der Merwe *Acta Juridica* (1964) 82, at 83-93; Van der Merwe and Olivier *Die Onregmatige Daad in die Suid-Afrikaanse Reg* (1989) 348-354; Boberg *The Law of Delict* (1984) 734; Van der Walt and Midgley *Delict: Principles and Cases* (1997) 72; Joubert *The Law of South Africa* (1999) Vol 8 Par 79; Van der Walt *Delict: Principles and Cases* (1979) 55. For case law see *Jameson's Minors v CSAR* 1908 TS 575; *Victor N.O. v Constantia Co Ltd* 1985 (1) SA 118 (C).

¹³⁸ For the writers who supports this controversial view see McKerron 53 *SALJ* (1936) 413; McKerron 67 *SALJ* (1950) 62; Walter Pollack 48 *SALJ* (1931) 191; Milner 72 *SALJ* (1955) 233; Schwietering 20 *THRHR* (1957) 138 at 144. For case law see *Union Government (Minister of Railways & Harbours v Matthee* 1917 AD 688; *Lampert v Hefer N.O.* 1955 (2) SA 507 (A) at 507; *Evans v Shield* 1980 (2) SA 814 AD; *Santam Insurance Co Ltd v Vorster* 1973 (4) SA 764 (A).

¹³⁹ 2004 (5) SA (SCA).

¹⁴⁰ See Winfield and Jolowicz (1989) 688.

success against a plaintiff by a defendant, as with *volenti*, certain requirements first have to be met.

In this regard, it has been stated before that the defence may only be invoked once it is established that the defendant has committed a tort against the plaintiff.¹⁴¹ Although actual knowledge of the risk, by the plaintiff, is necessary for the replication of the defence, it has been advocated that even where that knowledge is absent, the defendant may have discharged his duty by giving reasonable notice of the risk.¹⁴²

There is a belief amongst certain legal writers that in the absence of an agreement express or implied there can be no defence of assumption of risk.¹⁴³ But caution the writers, knowledge of risk does not necessarily lead to a finding that the plaintiff assented to the risk. What is required is an acceptance of the risk of harm.¹⁴⁴

A further requirement, as with consent in the defence of *volenti non fit iniuria*, is the plaintiff must have freely assumed the risk of harm, which is characterised by the absence of any feeling of constraint that may interfere with the plaintiff's freedom of will.¹⁴⁵

But, despite the parties having reached an express agreement that the plaintiff will voluntarily assume the risk of harm and his agreement is made before the negligent act, the defence will not succeed in instances where the parties freedom to agree is subject to statutory restrictions, for example the Unfair Contract Terms Act 1977.¹⁴⁶ In terms of the Unfair Contract Terms Act 1977 it is not possible to exclude liability for death or personal injury at all.

The defendant will therefore not be allowed to get around the act by saying that the plaintiff accepted the risk of harm.¹⁴⁷

¹⁴¹ See Winfield and Jolowicz (1989) 688.

¹⁴² See Winfield and Jolowicz (1989) 688.

¹⁴³ See Winfield and Jolowicz (1989) 688.

¹⁴⁴ See Winfield and Jolowicz (1989) 690-691.

¹⁴⁵ See Winfield and Jolowicz (1989) 691-692.

¹⁴⁶ See Brazier *Street on Torts* (1993) 110.

¹⁴⁷ See S.2 (1); S.2. (3) of the Unfair Contract Terms Act 1977.



The English position, with regard to the contractual exclusion or limitation of a dependant's claim, appears to be deeply governed by statutory provisions. In terms of the Congenital Disabilities (Civil Liability) Act ¹⁴⁸ which, with regard to the civil liability to a child born disabled, provide:

"1(6) *Liability to the child under this section may be treated as having been excluded or limited by contract made with the parent affected to the same extent and subject to the same restrictions as liability in the parent's own case, and a contract term which could have been set up by the defendant in an action by the parent, so as to exclude or limit his liability to him or her, operates in the defendant's favour to the same, but no greater, extent in an action under this section by the child.* ¹⁴⁹

The effect thereof has been that the child is bound by a contractual exclusion or limitation clause that would have applied to the parent's action. ¹⁵⁰

However, with the promulgation of the Unfair Contract Terms Act ¹⁵¹ the contractual exclusion clause which sought to exclude liability for death or personal injury caused by negligence would be ineffective. ¹⁵² Therefore the fact that the parents assumed the risk of harm or consents to the injury of harm does not include the autonomous claim of dependants."

7.2.2.2.2 Case Law

The English courts have in a number of cases pronounced on the validity of the defence of *volenti non fit iniuria* which, in reality, display clear overtones of assumption of risk on the facts. The defence of *volenti* was thus interchangeably used.

In the case of *Dann v Hamilton* ¹⁵³ the facts were: The defendant drove the plaintiff and her mother to London to see the Coronation lights. They visited several public houses and the defendant's ability to drive was clearly impaired. One passenger decided that the driver was drunk and got out of the car. The plaintiff said she would take the risk of an accident happening. A few minutes later there was an accident and the plaintiff was injured. It was held that *volenti* did not apply on these facts as the plaintiff had not consented to or absolved the defendant from subsequent negligence on his part. Asquith J stated that the defence of *volenti* was applicable where the plaintiff came to a situation where the danger

¹⁴⁸ Congenital Disabilities Act 1976.

¹⁴⁹ Sec 1 (6) of the Congenital Disabilities (Civil Liability) Act 1976.

¹⁵⁰ Jones *Medical Negligence* (1996) 50.

¹⁵¹ Unfair Contract Terms Act 1977.

¹⁵² Jones *Medical Negligence* (1996) 50; S2 (1) of the Unfair Contract Terms Act 1977.

¹⁵³ 1939) 1 KD 509.

had already been created by the defendant's negligence. In the subsequent case of *Nettleship v Weston*¹⁵⁴ the plaintiff gave the defendant driving lessons. On the third lesson the defendant drove negligently and hit a lamp post. The plaintiff was injured and sued in negligence. The action was successful and the defence of *volenti* failed. The plaintiff had not consented to run the risk of injury as he had checked on whether the car was covered for passenger's insurance. Lord Denning in delivering the judgement stated: "*Nothing will suffice short of an agreement to waive any claim for negligence. The plaintiff must agree, expressly or impliedly, to waive any claim for any injury that may befall him due to the lack of reasonable care by the defendant.*"¹⁵⁵

The defence subsequently also received the attention of the court in *Owens v Brimmell*,¹⁵⁶ in which the plaintiff and defendant spent the evening on a pub crawl together. The plaintiff accepted a lift home with the defendant, although he knew the defendant was drunk. The defendant drove negligently and the plaintiff received serious injuries in a crash. The defence of *volenti* was held to be inappropriate but the plaintiff's damages were reduced for his contributory negligence in riding with a drunken driver and failing to wear a seat belt. The court held, in these cases, that the plaintiff's been aware of the risk, but did not consent to the acts of negligence that caused their injuries. The court stated it was pointed out in *Dann v Hammlton*, that the defence could apply in cases where: '*the drunkenness of the driver at the material time is so extreme and so glaring that to accept a lift from him is like engaging in an intrinsically and obviously dangerous occupation, intermeddling with an unexploded bomb or walking along on the edge of an unfenced cliff.*'

In the case of *Morris v Murray*¹⁵⁷ which also involved assuming the risk of harm involving a drunken person, the plaintiff went for a ride in a private plane piloted by the defendant, despite the fact that he knew the defendant was drunk. The plane crashed and the plaintiff was injured. It was held by the Court of Appeal that the pilot's drunkenness was so extreme and obvious that participating in the flight was like engaging in an intrinsically and obviously dangerous occupation. The defence of *volenti* succeeded. Accepting lifts with drunken pilots is more dangerous than with drunken drivers.

¹⁵⁴ (1971) 2 QB 691.

¹⁵⁵ *Nettle ship v Weston* (1971) 2 QB 691.

¹⁵⁶ (1977) 2 W.L.R. 943.

¹⁵⁷ (1990) 3 ALL E.R. 801.

In a similar case involving the drunken driving of a motorbike the court in *Pitts v Hunt*¹⁵⁸ was confronted with the following facts: The plaintiff was a pillion passenger on a motor bike driven by the defendant. The defendant was drunk, had never passed a driving test, was uninsured and drove dangerously. The plaintiff encouraged him in this behaviour. The statutory provision of the Road Traffic Act 1988, S149 was held to prevent the defendant from relying on any form of the *volenti* defence. Had it not been for the section, the court was of the view that the claim would have been defeated by *volenti*.

I could find no case which deals with the effect of the parent(s) assuming the risk of harm or consenting to risk of injury or harm which affects the dependant's claim, in instances where the parent(s) contracts with a person or institution in terms of which, the parent(s) exempt the person or institution from such liability. It is respectfully submitted that should such a case arise in England, the dependants may successfully rely on the Unfair Contract Terms Act¹⁵⁹ to protect their interests. It is also submitted that the court will not deny the dependants their autonomous claim arising from the death or personal injury caused by the wrongdoer's negligence in terms of the said Act.

7.2.2.2.3 Legal Opinion

- (1) Although some writers regard voluntary assumption of risk as an extension of the maxim *volenti non fit iniuria*, there are English writers who do regard voluntary assumption of risk as a totally separate defence.¹⁶⁰
- (2) Before voluntary assumption of risk may successfully be invoked as a defence, the defendant may give reasonable notice of the risk and the plaintiff must have knowledge of the risk of harm.¹⁶¹
- 3) A further requirement is that the plaintiff must have freely assumed the risk of harm.¹⁶²

¹⁵⁸ (1990) 3 ALL E.R. 801.

¹⁵⁹ Unfair Contract Terms 1977.

¹⁶⁰ Winfield and Jolowicz *Tort* (1989) 688; Brazier *Street on Torts* (1993) 80ff. For case law see *Dann v Hamilton* (1939) 1 (U) 509; *Nettle ship v Weston* (1971) 2 QB 691; *Owens v Brimell* 1977 2 WLR 943; *Morris v Murray* 1990 (3) ALL ER 801.

¹⁶¹ Winfield and Jolowicz *Tort* (1989) 688-691.

¹⁶² Winfield and Jolowicz (1989) 691-692.

- (4) The Unfair Contract Terms Act 1977 however, prohibits the exclusion of liability for death or personal injury despite parties having reached an express agreement that the plaintiff will voluntarily assume the risk of harm. ¹⁶³
- (5) The Unfair Contract Terms Act 1977 protects dependants to claim successfully for loss of support, despite the fact that the parent(s) assumed the risk of harm or consented to the injury of harm, as dependants retain their autonomous and non-derivative claim.
- (6) The Act prohibits any contractual exclusion which sought to exclude liability for death or personal injury caused by negligence.

7.2.2.3 UNITED STATES OF AMERICA

7.2.2.3.1 Legal Writings

Assumption of risk is known in American Law as a fully fledged defence. ¹⁶⁴ It has, according to the American writers, been a subject of much controversy, in that, "assumption of risk" has been used in several different senses, but lumped together under the one name, often without realizing that differences exist in their usage. ¹⁶⁵ The term "assumption of risk" has also been used inter-changeably with the doctrine of "*volenti non fit iniuria*", especially in instances where the parties stand in a relationship of master and servant or employee and employer or at vastly different bargaining positions in some other contractual relationship. ¹⁶⁶

Whatever form it takes, it appears that in its most basic usage, assumption of risk means that the plaintiff, in advance, gives his express consent to relieve the defendant of an obligation of conduct towards him/her, and to take his/her chances of injury from a known

¹⁶³ SS2 (1); 2(3) of the Unfair Contract Terms Act 1977.

¹⁶⁴ See Page and Keeton *Prosser and Keeton on the Law of Torts* (1984) 480; See also Louisell and Williams *Medical Malpractice* (2001) 9.

¹⁶⁵ See Page and Keeton (1984) 480; See also Keeton "*Assumption of Risk in Products Liability Cases*" 1961, 22 *LA.L.REV.* 122 who classifies assumption of risk into no less than six different categories namely: express, subjectively consensual, objectively consensual, by consent to conduct or condition, associational, and imposed. See further Bohlen "Voluntary Assumption of Risk" 1966 20 *Harv.L.Rev* 14 91; Wade "The Place of Assumption of Risk in the Law of Negligence" 1961 22 *LA.L.REV.*5; Green "Assumed risk as a defence" 1961 *LA.L.REV.* 77.

¹⁶⁶ See Page and Keeton (1984) 480; See further Louisell and Williams (2001) 9.

risk arising from what the defendant is to do. ¹⁶⁷

In the ordinary case, for example where the one party accepts a gratuitous pass on a railway train, or enters into a lease agreement or rents a house or employees an agent or enters into some other relationship involving free and open bargaining between the parties, that there shall be no obligation to take precaution, there is no public policy conviction which prevents the parties from contracting as they see fit. ¹⁶⁸

There is broad consensus amongst the writers that where one party is at such disadvantage in bargaining power, the effect of which, is to put the one party at the mercy of the other's negligence, such agreements should not be upheld but rather declared void as against public policy. ¹⁶⁹

There has been a movement afoot in America to extend the same rule to those who provide a service to the public, yet they are under no public duty because of their occupation. They include garage men and owners of parking lots etc. A second situation of assumption of risk is where the plaintiff voluntarily enters into some relationship with the defendant, with the knowledge that the defendant will not protect him against one or more future risks that may arise from the relationship. In this instance he may be regarded as having tacitly consented to negligence, and agreed to take his own chances. ¹⁷⁰ Usually the implied assumption of risk is inferred from the conduct of the plaintiff, without there being an express agreement.

Nevertheless, he still knowingly and willingly encounters the risk. ¹⁷¹

¹⁶⁷ See Page and Keeton (1984) 480-481 who state that in so doing the "*defendant is relieved of his/her legal duty, to the plaintiff, and being under no duty, he/she cannot be charged with negligence.*" See also Louisell and Williams (2001) 9.2-9.3.

¹⁶⁸ See Page and Keeton (1984) 482.

¹⁶⁹ See Page and Keeton (1984) 482. The writers held the view that especially "*in instances where an employer is exempted from all liability for negligence towards his employees or efforts of public utilities to escape liability for negligence in the performance of their duty of public services should be held void as against public policy.*" See also Louisell and Williams (2001) 9.03. In this regard the writers opine that the American courts are quite hostile in attempts by hospitals and doctors to enforce exculpatory clauses in admission and consent in treatment forms.

¹⁷⁰ See Page and Keeton (1984) 483. The writers motivate for the extension of the rule on the ground that "*the indispensable need for their services deprives the customer of a real equal bargaining power.*" Public interests thus demands for an extension of the rule. In this regard the writers mentions the leading case of *Tunkl v Regents of University of California* 1963, 60 Cal2d 92, 32 Cal.Rptr. 33, 383 P.2d 441; the same rule was applied to a charitable hospital accepting patients from the public, upon the ground that the "public interest" was involved. See also Louisell and Williams (2001) 9.02 who argue that hospitals perform activities thought suitable for public regulation. In hospital-patient contracts there is a disparity power in equal bargaining.

¹⁷¹ See Page and Keeton (1984) 481. The writers regard as examples of tacit consent to negligence instances where a person commences employment, knowing that he is expected to risk with a dangerous horse or ride in a car

A third situation of assumption of risk occurs where the plaintiff is aware of a risk that has already been created by the negligence of the defendant, yet chooses, voluntarily to proceed to encounter it.¹⁷²

In order to succeed with a defence of assumption of risk the defendant must show or prove the following:

Firstly, the plaintiff must know that the risk is present and understand the nature of the risk.¹⁷³ Secondly, the plaintiff's choice to incur the risk, must be freely and voluntary.¹⁷⁴ There are however instances in American law where despite the requirements of knowledge of risk and voluntariness being present, nevertheless, because of a legal duty¹⁷⁵ owed by a defendant to the plaintiff or the existence of a statute which is clearly intended to protect the plaintiff, the defendant will not successfully invoke the defence of assumption of risk.¹⁷⁶

Despite its recognition, there is doubt whether the doctrine of "assumption of risk" as a defence, will ever be successfully invoked by a physician in practise. It is especially Holder who bespeaks the functionality of the doctrine when he states:¹⁷⁷

"Since most patients' knowledge of medicine does not permit them to understand these risks, without clear proof of totally informed consent, the defence of assumption of risk is not successful."

It appears therefore that the defence will only be successful in exceptional cases.

7.2.2.3.2 Case Law

The defence of assumption of risk is widely recognized in the American case law. The

where he knows the brakes are defective; See also Louisell and Williams (2001) 9.02.

¹⁷² See Page and Keeton (1984) 481; See also Louisell and Williams (2001) 9.5-9.6.

¹⁷³ See Page and Keeton (1984) 486. In this situation the writers uses as examples plaintiffs who enter business premises as invitees and discover dangerous conditions for example slippery floors or unsafe stairways. Though the invitees are aware of the risks, they nevertheless proceed freely and voluntarily to encounter them.

¹⁷⁴ See Page and Keeton (1984) 487. This is often according to the writers referred to as "knowledge of risk". The writers express the view that actual knowledge of the required risk is a prerequisite.

¹⁷⁵ See Page and Keeton (1984) 490. The writers state that *"the plaintiff is barred from recovery only if his choice is a free and voluntary one."*

¹⁷⁶ See Page and Keeton (1984) 492. In instances where because of a legal duty the defendant is obliged to exercise reasonable care for the plaintiff's safety. In such cases the plaintiff does not assume the risk when he proceeds to engage the defendant's services or facilities where also there is a statute intended to protect the plaintiff against his own inability to resist pressures the plaintiff may not assume the risk of the violation. The statute is held to override the private agreement.

¹⁷⁷ See Holder (1975) 306.

history underlying the development of the doctrine is set out in the case of *Tiller v Atlantic Coast Line R.Co.*¹⁷⁸ in which Mr Justice Black stated:

*"Perhaps the nature of the present problem can best be seen against the background of one hundred years of master-servant tort doctrine. Assumption of risk is a judicially created rule which was developed in response to the general impulse of common law courts at the beginning of this period to insulate the employer as much as possible from bearing the "human overhead" which is an inevitable part of the cost to someone of the doing of industrialized business. The general purpose behind this development in the common law seems to have been to give maximum freedom to expanding industry."*¹⁷⁹

Certain principles in that case has been followed in a number of other cases *inter alia* *Siragusa v Swedish Hospital*,¹⁸⁰ a case decided by the Supreme Court of Washington which includes:

An action by a nurse's aid against her employer for injuries sustained while at work. As she was standing at the wash basin in a six-patient ward, a patient in a wheelchair pushed the door inward. On the door was a metal hook placed there to permit persons to open the door from the inside with a forearm. This hook struck the upper part of the plaintiff's back. Plaintiff asserted that defendant was negligent in failing to provide her a safe place to work. Defendant denied negligence and asserted contributory negligence and assumption of risk. On appeal following the remarks made by Frankfurter J in the Tiller case in which the Judge explained the application of the maxim as follows:

" assumption of risk, has been used as a shorthand way of saying that although an employer may have violated the duty of care which he owed his employee, he could nevertheless escape liability for damages resulting from his negligence if the employee, by accepting or continuing in the employment with "notice" of such negligence, "assumed the risk". In such situations "assumption of risk" is a defence which enables a negligent employer to defeat recovery against him."

The court reasons that the defence is available *"only if the employer's duty is relegated to one of providing warning is it fair or just to allow a defence to the employee's action on the ground that the employee "received" warning from his self-acquired knowledge and appreciation of the risk involved."*

As to what is true and desirable the court held:

" the employer has the positive duty to furnish a reasonably safe place to work, it is not just or fair to permit an employer to escape liability for a failure to perform this duty simply because the employee was aware of the danger when he reasonably elected to expose himself to it while in the course of his employment. To do so is to affirm and deny in the same breath, the employer's duty of care."

The court subsequently concluded:

"The time has now come, therefore, to state unqualifiedly that an employer has a duty to his employees to exercise, reasonable care to furnish them with a reasonable safe place to work. We now hold that if an employer

¹⁷⁸ 3 18 U.S. 54, 63 S.CT 444, 87 L.E.D. 619 (1943).

¹⁷⁹ *Tiller v Atlantic Coast Line R.Co.* 3 18 U.S. 54, 63 S.CT 444, 86 L.E.D. 610 (1943).

¹⁸⁰ 60 WASH 2d 310, 373 P.2d. 767 (1962).

*negligently fails in this duty, he may not assert, as a defence to an action based upon such a breach of duty, that the injured employee is barred from recovery merely because he was aware or should have known of the dangerous condition negligently created or maintained. However, if the employee's voluntary exposure to the risk is unreasonable under the circumstances, he will be barred from recovery because of his contributory negligence. Knowledge and appreciation of the risk of injury, on the part of the employee, are properly important factors which should be given weight in the determination of the issues of whether the employer is negligent in maintaining the dangerous condition and whether the employee is contributory negligent in exposing himself to it."*¹⁸¹

The defence of assumption of risk has also frequently been raised in the so-called 'motorist' cases in which a guest passenger sues the driver after a collision, and the driver, in order to escape liability, raises the defence of assumption of risk. This scenario formed the subject of appeal in the case of *Moconville v State Farm Mutual Automobile Insurance Co*,¹⁸² in which the Supreme Court of Wisconsin, reviewing the legal position with regard to the doctrine of assumption of risk which previously provided that:

"..... an automobile host should not be held to as high a standard of responsibility for injury to his guest as for injury to one not in that relationship. The principle represents an evaluation of the relationship itself, including a concept that the guest is in the automobile as a matter of grace, not right, that he is free to ride or not ride and must protest or else be silent, at his own risk, and that the host as a benefactor of the guest merits protection from liability to one to whom the host has extended a favour."

Commenting on the previous dispensation the court held:

"This evaluation, this policy judgement, and these concepts do not appear sufficiently valid under present-day customs and community attitude toward the use of automobiles. We therefore adopt the following rules of law: (1) The driver of an automobile owes his guest the same duty of ordinary care that he owes to others; (2) A guest's assumption of risk, heretofore implied from his willingness to proceed in the face of a known hazard is no longer a defence separate from contributory negligence; (3) If a guest's exposure of himself to a particular hazard be unreasonable and a failure to exercise ordinary care for his own safety, such conduct is negligence, and is subject to the comparative negligence statute."

Consequently the court held that: *"..... The limitation on the duty of the automobile host under these, and other decisions, is no longer consistent with sound policy. A driver of an automobile should be held to the full standard of duty of ordinary care to his guests, as he is to other users of the highways."*

Protecting the interests of the passenger the court held:

*"It has been suggested that the doctrine of assumption of risk is one of implied consent where the guest has acquiesced in a course of negligent driving. Consent seems not to be a satisfactory basis for retaining the doctrine of assumption of risk. The consequences of an automobile accident to a guest may be so disastrous that it would be contrary to public policy to hold that an individual who consents by implication to a dangerous situation will go uncompensated for his injuries. Conduct which has heretofore been denominated assumption of risk may constitute contributory negligence as well."*¹⁸³

The defence of assumption of risk was also recognised in the case of *Lyons v Redding*

¹⁸¹ *Siragusa v Swedish Hospital* 60 WASH. 2d 310, 373 P.ed. 767 (1962).

¹⁸² 15 WIS. 2d 374, 113 N.W. 2d 14 (1962).

¹⁸³ *Moconville v State Farm Mutual Automobile Insurance Co*. 15 WIS. 2d 374, 113 N.W. 2d 14 (1962).

Construction Co ¹⁸⁴ but the court stated the defence should be limited to two situations namely:

"(a) When there is an express agreement to assume a risk and (b) when plaintiff has encountered a risk or danger with knowledge of "wilful, wanton, or reckless negligence of the defendant." ¹⁸⁵

7.2.2.3.3 Legal Opinion

- (1) The doctrine of assumption of risk, though the subject of much controversy as to whether it exists independently or not, has found recognition amongst legal writers as a fully fledged defence. ¹⁸⁶
- (2) The effect of the doctrine amounts to the plaintiff giving in advance his/her express consent to relieve the defendant of an obligation of conduct towards him/her, and to take his/her chances of injury from a known risk arising from what the defendant is to do. ¹⁸⁷
- (3) For the defence to be invoked successfully by a defendant, it must be shown.
 - (3) (1) the plaintiff was made aware of the risk present and understood the nature of the risk. ¹⁸⁸
 - (3) (2) that the plaintiff's choice to incur the risk was free and voluntary. ¹⁸⁹
- (4) But, notwithstanding the plaintiff being made aware of the risk, understanding the nature of the risk and freely and voluntarily choosing to incur the risk, there are instances in which the defendant will not escape liability. Factors which militate against the recognition of the defence assumption of risk under those

¹⁸⁴ 83 WN. 2d 86, 515 P. 2d 821 (1973).

¹⁸⁵ *Lyons v Redding Construction Co* 83 WN. 2d 86, 565 P. 2d 821 (1973).

¹⁸⁶ Page and Keeton *Prosser and Keeton on the Law of Torts* (1984) 480; Louisell and Williams *Medical Malpractice* (2001) 0.02; Bohlen "Voluntary Assumption of Risk" 1966 20 *HARV.L.REV.* 14 91, Wade "The Place of Assumption of Risk in the Law of Negligence" 1961 22 *LA.LAW REV* 5; Green "Assumed risk as a defence" 1961 *LA. LAW REV* 77. For case law see *Tiller v Atlantic Coast Line R.Co.* 318 US 54, 63 S.CO 444, 87 L.Ed 610 (1943); *Strigusa v Swedish Hospital* 60 WASH. 2d 310, 373, P.2d 767 (1962); *Moconville v State Farm Mutual Automobile Insurance Co* 15 WIS 2d 374, 113 N.W. 2d 14 (1962); *Lyons v Redding Construction Co* 83 WN 2d 86, 515, P.2d 821 (1973).

¹⁸⁷ Page and Keeton *Prosser and Keeton on the Law of Torts* (1984) 480-481; Louisell and Williams *Medical Malpractice* (2001) 9.2-9.3.

¹⁸⁸ Page and Keeton *Prosser and Keeton on the Law of Torts* (1984) 480-481. For case law see *Siragusa v Swedish Hospital* 60 WASH 2d 310, 373 P2d (1962); *Tiller v Atlantic Coast Line R.Co.* 3 18 US 54, 63 SCT 444, 87 LED 610 (1943).

¹⁸⁹ Page and Keeton *Prosser and Keeton on the Law of Torts* (1984) 487.

circumstances include:

- (4) (1) where the defendant is under a public duty or legal duty in terms of a statute to furnish a reasonably safe environment alternatively to exercise a duty of care. ¹⁹⁰
- (4) (2) where the one party is at such disadvantage in bargaining power, the effect of which is to put the one party at the mercy of the other's negligence. ¹⁹¹
- (4) (3) a contractant ought not to be allowed to contract out of his/her own negligence in breach of his/her duty of care in respect of the other contractant. ¹⁹²

7.3 Limiting or Excluding Liability in a Medical Context

7.3.1 *Volenti non fit iniuria*/Assumption of Risk in a Medical Context

7.3.1.1 SOUTH AFRICA

7.3.1.1.1 Legal Writings

The defence of *volenti non fit iniuria* as a ground of justification for medical interventions is recognised by legal writers. ¹⁹³

The recognition of the defence of *volenti non fit iniuria* stems from doctor/hospital/other healthcare providers contractual relationship with the patient, in which the consent of the patient plays a fundamental role. ¹⁹⁴

Save for emergency situations, statutory authority and authorization by the court, the general rule is that the patient's consent is a prerequisite for medical interventions. ¹⁹⁵

¹⁹⁰ Page and Keeton *Prosser and Keeton on the Law of Torts* (1984) 483, 490-492; *Tunkle v Regents of University of California* 1963 60 CAL 2d 92, 32 CAL.RPTR 33, 383 P. 2d 441; *Siragusa v Swedish Hospital* 60 WASH.2d 310, 373 P.2d 767 (1962).

¹⁹¹ Page and Keeton (1984)482; Louisell and Williams *Medical Malpractice* (2001) 9.02; *Tunkle v Regents of University of California* 1963, 60 CAL 2d 92, 32 CAL. RPTR. 33 383 P2d 441.

¹⁹² *Siragusa v Swedish Hospital* 60 WASH 2d 310, 373 P2d, 767 (1962).

¹⁹³ Van Oosten *Encyclopaedia* (1996) 63; Strauss and Strydom (1967) 175; Strauss (1984) 3ff; Claassen and Verschoor (1992) 57ff; Strauss (1991) 3ff 91ff; McQuoid-Mason and Strauss (1983) Par 192; Gordon Turner and Price (1953) 153; Schwär Loubser and Olivier (1984) 8ff; Carstens and Pearman (2007) 591ff.

¹⁹⁴ Van Oosten *Encyclopaedia* (1996) 63ff; Strauss and Strydom (1967) 175; Strauss (1991) 3ff; Claassen and Verschoor (1992) 57ff; Strauss (1991) 3ff 91ff; McQuoid-Mason and Strauss (1983) Par 192; Gordon Turner and Price (1953) 153; Schwär Loubser and Olivier (1984) 8ff; Carstens and Pearman (2007) 591ff.

¹⁹⁵ Van Oosten *Encyclopaedia* (1996) 63ff; Strauss and Strydom (1967) 175; Strauss (1991) 3ff; Claassen and

The absence of consent from the patient himself/herself, or of someone acting on the patient's behalf, has the effect that the medical intervention is wrongful or unlawful unless justified in law or excused in law.¹⁹⁶ The legal consequences that flow there-from are that the doctor/hospital/other health care provider may be criminally prosecuted for assault and/or face civil action for damages.¹⁹⁷

The presence of consent has the effect that an act which is *prima facie* actionable deprives the plaintiff of the right afterwards to complain of it. The maxim applicable in such a case is known as *volenti non fit iniuria*.¹⁹⁸

Before the defence of *volenti non fit iniuria* may be said to be legally operative, certain requirements must first be met, inter alia: The patient must have knowledge of the procedures to be followed, the patient appreciates their consequences and nevertheless consents to them, the patient must have the legal capacity to consent, the consent given must be recognised by law: That is, it must conform with the dictates of society, the so-called *boni mores*.¹⁹⁹ The requirements are now also legislatively controlled.²⁰⁰

It is particularly the latter requirement which is of great importance to the core of this thesis, namely whether a doctor/hospital/other healthcare provider may validly include in a written agreement with a patient a term, releasing him from any legal obligation to show due skill and care, for such conduct?

Put differently, whether a patient's consent releasing a doctor/hospital/other healthcare provider from a legal obligation to show due skill and care would be valid, alternatively void as against public policy? The writers Gordon, Turner and Price²⁰¹ persuasively argue that in

Verschoor (1992) 57ff; Strauss (1991) 3ff 91ff; McQuoid-Mason and Strauss (1983) Par 191; Carstens and Pearman (2007) 875ff. Legislative intervention in the form of the National Health Act 61 of 2003 today also provides for the healthcare user's consent for medical intervention save for certain circumstances.

¹⁹⁶ Claassen and Verschoor (1992) 57ff; Strauss (1991) 3ff; McQuoid-Mason and Strauss (1983) Par 191; Van Oosten *Encyclopaedia* (1996) 63; Strauss and Strydom (1967) 182ff; Carstens and Pearman (2007) 890ff.

¹⁹⁷ McQuoid-Mason and Strauss (1983) Para 191; Van Oosten *Encyclopaedia* (1996) 63; Strauss and Strydom (1967) 185ff; Strauss (1984) 3; Claassen and Verschoor (1992) 57ff; Strauss (1991) 91ff; Gordon Turner and Price (1953) 153ff; Carstens and Pearman (2007) 890ff.

¹⁹⁸ Gordon Turner and Price (1953) 153ff, 188ff; McQuoid-Mason and Strauss (1983) Par 192; Strauss and Strydom (1967) 182ff 317; Carstens and Pearmain (2007) 591ff.

¹⁹⁹ McQuoid-Mason and Strauss (1983) Par 192; Van Oosten *Encyclopaedia* (1996) 64ff; Strauss and Strydom (1967) 182ff; Claassen and Verschoor (1992) 59ff; Strauss (1984) 4ff; Strauss (1991) 4ff; Gordon Turner and Price (1953) 153ff, 188ff; Carstens and Pearman (2007) 883.

²⁰⁰ Sections 6-9 of the National Health Act 61 of 2003.

²⁰¹ (1953) 188-189.

the so-called "contracting out" of liability cases involving medical practitioners, although consent may be clearly established, it may be of only very limited effect, that is, "*consent can only protect the surgeon against a claim for assault*" and further "*any attempt by a practitioner to contract out of liability for malpractice may be considered by the courts to be void as against public policy, leaving the patient's right to sue for damages unimpaired.*"

The writers continue to argue 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.*" ²⁰²

More recently the South African Supreme Court of Appeal in the case of *Afrox Healthcare Bpk v Strydom* ²⁰³ took the view that although a contractual clause that offends public policy is unenforceable, it nevertheless, decided that a contractual clause in a hospital contract which indemnifies a hospital against liability for negligence is valid, but left open the question where gross negligence is shown. This dictum has subsequently, deservedly, undergone severe criticism. It is especially the writers Carstens and Kok ²⁰⁴ who persuasively criticise this judgement. For their insightful reasoning see the discourse *supra*.
²⁰⁵

In so far as assumption of risk as a defence in a medical context is concerned, very little attention has been given by our legal writers to this subject matter. Our legal writers do however, in general terms, recognise a voluntary acceptance of risk which in broad terms amounts to this, the aggrieved person with full knowledge and intent, subjected him/her to a risk of harm which another person created. Should the aggrieved person then afterwards suffer harm, he/she cannot afterwards claim damages from the perpetrator. Our positive law has, however, placed limitations on the recognition of this defence, in that an aggrieved party, notwithstanding his/her consent to the assumption of risk, still retains his/her right to recovery in instances where the perpetrator's conduct is contrary to public policy or where the granting of the action is not contrary to public policy. ²⁰⁶

²⁰² Gordon Turner and Price (1953) 153ff 188ff; *Contra*, Van Oosten (1996) 88. See also Strauss (1991) 305; Claassen and Verschoor (1992) 102-103; Burchell and Schaffer (February 1977) 109-115. *Contra*, Cronje-Retief (2000) 440-41; Carstens and Pearmain (2007) 458.

²⁰³ 2002 (6) SA 21 SCA.

²⁰⁴ "An assessment of the use of disclaimers by South African hospitals in view of Constitutional demands, Foreign Law and medico-legal considerations" (2007) 78 *SAPR/PL* 430 18.

²⁰⁵ Chapter 14 Page 1177.

²⁰⁶ Strauss and Strydom (1967) 317ff.

To the question of whether a medical practitioner, who through his/her negligence causes physical harm to a patient or jeopardises the patient's health, can escape liability by invoking the defence of voluntary assumption of risk, Strauss & Strydom²⁰⁷ in particular have come out strongly against the surgeon escaping liability.

7.3.1.1.2 Case Law

The defence of consent to intended harm in the performance of surgical operations received the attention of our courts as far back as 1923. In the case of *Stoffberg v Elliot*²⁰⁸ Watermeyer J put the position as follows:

"Any bodily interference with or restraint of a man's person which is not justified in law, or excused in law, or consented to, is a wrong, and for that wrong the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to that interference. I said 'not justified, or not excused, or not consented to'; now, by 'justified' I mean this: there are certain interferences with the body of another which are justified and perfectly lawful, for instance, when a police constable arrests another under a warrant, or when an executioner hangs a man If the interference is consented to, then it is not a wrong..... "

Watermeyer J continues:

*" 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."*²⁰⁹

In a subsequent medical malpractice case of *Esterhuizen v Administrator, Transvaal*²¹⁰ the court unequivocally recognised the maxim *volenti non fit iniuria* when Bekker J, referring with approval to the dictum of Schreiner JA, in *Lampert v Hefer* NO stated:

"It is usual to include in the defence volenti non fit iniuria, or as I call it for convenience, consent, cases of voluntary acceptance of risk as well as cases of permission to inflict intentional assaults upon oneself, as in the case of surgical operations."

Bekker J continues:

"Generally speaking, all the numerous authorities without exception indicate that, to establish the defence of volenti non fit iniuria 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. Furthermore, in the matter of Rompel v Botha (TPD 15 April 1953, unreported), Nesor J held:

There is no doubt that a surgeon who intends operating on a patient must obtain the consent of the patient. In

²⁰⁷ (1967) 320-321.

²⁰⁸ 1923 CPD 148.

²⁰⁹ *Stoffberg v Elliot* 1923 CPD 148.

²¹⁰ 1957 (3) SA 710 (T).

such cases where it is frequently a matter of life and death I do not intend to express an 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 risk 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."

Endorsing the stated principle Bekker J concludes:

"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." ²¹¹

In a more recent judgement concerning the recognition of the maxim *volenti non fit iniuria*, which in South African Law can take the form of informed consent Ackermann J in *Castell v De Greef* ²¹² held:

"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 iniuria, which would justify an otherwise wrongful delictual act. (See, inter alia, Stoffberg v Elliot 1923 CPD 148 at 149-50; 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)."

Ackermann J continues:

"South African law generally classifies volenti non fit iniuria, irrespective of whether it takes the narrower form of consent to a specific harm or the wider form of assumption of risk of harm, as a ground of justification (regverdigingsgrond) excludes the unlawfulness or wrongfulness element of a crime or delict."

Ackermann J then lays down certain criteria which must be satisfied before the defence of *volenti non fit iniuria* may successfully be relied upon:

- (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 harm or risk';
- (d) The consent 'must be comprehensive that is extending to the entire transaction, inclusive of its consequences'. ²¹³

²¹¹ *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T).

²¹² 1994 (4) SA 408 (C).

²¹³ See *Castell v De Greef* 1994 (4) SA 408 (C). Owing to constraints and focus being placed on the focal point of this thesis, it is impossible to go into an in-depth discussion regarding the general principles of informed consent

7.3.1.1.3 Legal Opinion

- (1) What emanates from the doctor/hospital/other healthcare provider's contractual relationship with the patient wherein the consent of the patient plays a fundamental roll is the recognised defence of *volenti non fit iniuria* which serves as a ground of justification.²¹⁴
- (2) As consent is a prerequisite for medical interventions,²¹⁵ consent is present, an act which is *prima facie* actionable may, provided the requirements are met, be denounced as actionable, deprive the plaintiff of the right to complain afterwards, as the maxim *volenti non fit iniuria* may successfully be invoked.
- (3) Before the maxim *volenti non fit iniuria* may successfully be raised as a defence it must be shown inter alia: the patient did have sufficient knowledge of the procedure to be followed; the patient appreciated the consequences and nevertheless, consented thereto. The consent given must be recognised by law, that is, it must conform to the dictates of society, the so-called *boni mores*.²¹⁶

and their application in the South African law. The idea here was basically to give an overview in very broad terms of informed consent as a defence and how it can be utilized in negating wrongfulness in cases concerning medical treatment or intervention. For further reference on the South African case law see: *Allott v Paterson & Jackson* 1936 (SR) 221; *Buls v Tsatsarolakis* (1976) (2) SA (T) 891; *Castell v De Greef* (1993) (3) SA 5-1 (C); *Castell v De Greef* 1994 (4) SA 408 (C) 426; *Esterhuizen v Administrator, Transvaal* 1953 (3) SA 710 (T); *Ex parte Dixie* (1950) (4) SA 748 (W); *Lampert v Hefer* 1955 (2) SA 507 (A); *Lymbery v Jefferies* 1965 (AD) 236; *Phillips v De Klerk* 1983 (T) Unreported case; *Richter v Estate Hammann* 1976 (3) SA 226; *Rompel v Botha* (1953) (T) unreported; *Stoffberg v Elliott* 1923 (C) 148; *Verhoef v Meyer* 1975 (T); 1976 (A) unreported discussed by Strauss *Doctor Patient and The Law* (1989) 32.

²¹⁴ Van Oosten *Encyclopaedia* (1996) 63; Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 175; Claassen and Verschoor *Medical Negligence* (1992) 57ff; Strauss *Doctor Patient and The Law* (1991) 3ff 91ff; McQuoid-Mason and Strauss *Law of South Africa* Vol 17 (1987) Par 192; Gordon Turner and Price *Medical Jurisprudence* (1955) 153; Schwär Loubser and Olivier *Die ABC van Geregte Geneeskunde* (1984) 8ff; See also Carstens and Pearman *Foundational Principles of South African Medical Law* (2007) 875ff. In so far as case law is concerned, one of the first cases in which the defence of consent to intended harm in the performance of surgical operations arose was that of *Stoffberg v Elliot* 1923 CPD. The court however, did not refer to *volenti non fit iniuria* as a defence. Our courts did however sometime later in the case of *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T) recognises the maxim. In a more recent judgement in the case of *Castell v De Greef* 1994 (4) 408 (C) the Cape Provincial Division continued to recognize the defence of *volenti non fit iniuria*. For other cases see *Lymbery v Jefferies* 1925 AD 236 at 240, *Lampert v Hefer* NO 1955 (2) SA 507 (A) at 508; *Verhoef v Meyer* 1975 (TPD) and 1976 (A) (Unreported), discussed by Strauss (1991) 35-6.

²¹⁵ Gordon Turner and Price *Medical Jurisprudence* (1953) 153ff 188ff; McQuoid-Mason *The Law of South Africa* Volume 17 (1983) Par 192; Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 182ff, 317; Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 878ff.

²¹⁶ McQuoid-Mason *The Law of South Africa* Vol 17 (1983) Par 192; Van Oosten *Encyclopaedia* (1996) 64ff; Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* 182ff; Claassen and Verschoor *Medical Negligence* (1992) 59ff; Strauss *Doctor Patient and the Law* (1991) 4ff; Gordon Turner and Price *Medical Jurisprudence* (1953)

- (4) In the so-called "contracting out" of liability cases involving medical practitioners, nonetheless, our legal writers opine that in those circumstances consent can only protect the medical practitioner against a claim of assault. It is persuasively argued by some writers that any attempt, by a practitioner, to contract out of liability for malpractice ought to be declared void as against public policy, leaving the patient's right to sue for damages unimpaired. This view I respectfully associate myself with.²¹⁷ For a more fully detailed motivation therefore see *infra*.
- (5) Assumption of risk as a defence in a medical context has received scant attention from our legal writers and the courts alike. Although our legal writers do, in general terms, recognise voluntary assumption of risk as a defence, nonetheless, limitations are placed on the defence in, for example, instances where the perpetrator's conduct is contrary to public policy or where the granting of the action is not contrary to public policy.²¹⁸ In a medical context, it is especially Strauss and Strydom²¹⁹ who persuasively argue that societal dictates demand that, in executing his/her profession, the medical practitioner ought not to be allowed to compromise the degree of care and skill expected of the medical practitioner. A relaxation thereof, cautions the writer, would lead to a distortion of recognised medical norms and ethics.²²⁰

7.3.1.2 ENGLAND

7.3.1.2.1 Legal Writings

Consent to medical treatment and/or surgery in English law, is an integral part of medical

153ff, 188ff; Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 937.

²¹⁷ See Gordon Turner and Price *Medical Jurisprudence* (1953) 153ff 188ff; 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" (2002) 18 *SAPR.PL* 430 18. The latter writer includes the position of hospitals when making use of indemnity clauses or exculpatory clauses in hospital contracts. Support for this view can also be found in Cronje-Retief *The Legal Liability of Hospitals* (2000) 440-441. Carstens and Pearmain *Foundational Principles of South African Medical Law* (2007) 458ff *Contra* however, Van Oosten *Encyclopaedia* (1996) 88; Burchell and Schaffer "Liability of Hospital for Negligence" February 1997 *Businessman's Law* 109-111, Claassen and Verschoor *Medical Negligence* (1992) 102-103; Strauss *Doctor, Patient and The Law* (1991) 102-103. See also the controversial decision by the Supreme Court of Appeal in *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 SCA.

²¹⁸ Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 317ff. For case law see *Castell v De Greef* 1994 (4) SA 408 (C) in which the court recognised assumption of risk of harm as a wider form of *volenti non fit iniuria*.

²¹⁹ Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 320-321.

²²⁰ Strauss and Strydom *Die Suid-Afrikaanse Geneeskundige Reg* (1967) 320-321.

treatment, the failure whereof, *prima facie*, constitutes battery ²²¹ or trespass. ²²²

For that reason it is generally accepted that consent to medical treatment by a patient, in certain instances, may be invoked successfully, by a physician, in a medical negligence suit as a valid defence. In this regard the doctrine of *volenti non fit iniuria* in a medical context also plays a significant role in English law. ²²³

When applying the concept consent in a medical context, the question arises, to what extent should the patient be informed by the physician in order to constitute real consent? The answer lies in the following of the American law, in receiving certain principles pertaining to "informed consent" into the English law. It is particularly the nature and scope of the physician's duty of disclosure to the patient and the question whether the absence of "informed consent", by the patient, constitute negligence that received a tremendous amount of attention amongst the legal writers. ²²⁴

Where a physician carries out treatment of a patient and/or performs an operation on a patient without the necessary consent, the patient may sue the physician for damages which claim may be founded in the so-called battery ²²⁵ or trespass ²²⁶ otherwise known

²²¹ See Street *The Law of Torts* (1993) 82; See also Scott (1995) 85.

²²² See Winfield and Jolowicz *Tort* (1989) 682-683.

²²³ See Milner *Negligence in Modern Law* (1967) 99 who describes the rationale of the defence of *volenti non fit iniuria* as follows: "*The negation of negligent conduct may be presented in the form of as contention that no duty is owed to one who consents to the defendant's act, either to a specific act of a harmful nature, or to an activity which involves the risk of harm. Volenti non fit iniuria - no wrong is done to a willing party ... the philosophical premise of this rule is the freedom of the will, that is, the freedom to choose between alternatives, coupled to the social outlook that each man is master of his fate and the best judge of his own wellbeing.*" See also Jackson and Powell (1997) 317; Kennedy and Grubb (1998) 171 ff; Mason and McCall-Smith (1987) 120; Skegg (1984) 88; See further Winfield and Jolowicz (1989) 691; Street (1993) 82-83; Scott (1995) 91.

²²⁴ With regard to the nature and scope of the physician's duty to provide information to his/her patient see Skegg (1984) 88 who states: "*Generally speaking, the greater the patient's capacity to comprehend the issues involved and come to a decision about them, the greater will be the extent of the duty to disclose relevant information. Conversely the more restricted his capacity - whether by reason of his current medical condition, limited intelligence or education, or the complexity of the issues involved - the less may be the extent of any duty to inform.*" Factors which influence the physician's duty of disclosure include the capability of the patient to understand the nature and scope of the medical treatment; to what extent the patient desires information regarding the proposed treatment; the nature and scope of the proposed treatment and/or surgical procedure and the effect of the said information on the patient. For a comprehensive discussion see Skegg (1984) 88-92; See also the discussion by Mason and McCall-Smith (1987) 120; Winfield and Jolowicz (1989) 685 suggest that "... *So long as the patient understands the broad nature of what is to be done, his consent is not vitiated by failure to explain the risks inherent in the procedure....*" See further Street (1993) 82; Scott (1995) 88-89; Kennedy and Grubb (1998) 215ff. There are however situations which may arise where the patient is not in a position to consent for example the patient may be unconscious, the patient is a minor or the absence of consent is predicated by an emergency situation. For a full discussion see Kennedy and Grubb (1998) 180ff; Mason and McCall-Smith (1987) 112-117; Winfield and Jolowicz (1989) 684-685; Street (1993) 82-84. The foretasted topic however falls outside the scope of this discussion.

²²⁵ See Street (1993) 83; Brazier (1992). Battery is defined by Flemming *The Law of Torts* (1977) 27 as: "*the*

simply as negligence, in not securing the necessary consent.

Consent to one medical procedure does not justify another. Where a condition is discovered during the authorised treatment of another condition or during an operation, the physician first has to obtain consent to treat the newly discovered condition.²²⁷

At common law, in the absence of duress or some other vitiating factor, entry into a contract exempting the defendant from liability for negligence was, prior to the promulgation of the Unfair Contract Terms Act in 1977, a complete defence. The effect of the common law position was that the freedom to contract was overriding, in that, once the contracting party signed the agreement, even though the agreement included an exclusion of liabilities term, the parties were bound by the agreement. This was the position, notwithstanding one of the parties not having read the agreement prior to signing.²²⁸

The position changed dramatically, however, with the promulgation of the Unfair Contract Terms Act of 1977, which resulted in a limitation being placed on contractual freedom in that, parties to the contract were no longer by reference to any contract term, free to exclude or restrict their liability for death or personal injury resulting from negligence.²²⁹ The same principle is advocated when a physician and patient have reached an express agreement that the plaintiff will voluntarily assume the risk of harm.²³⁰

7.3.1.2.2 Case Law

Consent as an integral part of medical treatment is recognised in English case law. In the *locus classicus* of *F v West Berkshire Health Authority*²³¹ the court looked at the

intentional application of force to the person of another, the force being harmful or offensive, and being without the consent of that other and without lawful excuse." The doctrine of *volenti non fit iniuria* is firmly entrenched in the definition in that where a patient consents and provided all the requirements are met the physician is lawfully excused.

²²⁶ See Winfield and Jolowicz (1989) 683-685. The writers opine that where the physician failed to perform the duty to warn the patient of risks, the plaintiff may nevertheless succeed with his/her claim even though the operation has been carried out with all due care and skill, provided the patient can show he/she would not have consented; See also Street (1993) 83; Jackson and Powell (1997) 317; Kennedy and Grubb (1998) 215; Mason and McCall-Smith 117; Skegg (1984) 79.

²²⁷ Winfield and Jolowicz (1989) 685.

²²⁸ Harwood *Principles of Tort Law* (1997) 110.

²²⁹ S 2(1) of the Unfair Contract Terms Act 1977.

²³⁰ Harwood *Principles of Tort Law* (1997) 140.

²³¹ (1989) 2 ALL ER 545 (1990) 2 AC 1 (1989) 2 WLR 938.

consequences of treatment without consent. Lord Brandon summed up the position as follows:

"At common law a doctor cannot lawfully operate on adult patients of sound mind, or give them any other treatment involving the application of physical force however small (which I shall refer to as 'other treatment'), without their consent. If a doctor were to operate on such patients, or give them other treatment, without their consent, he would commit the actionable tort of trespass to the person."

Lord Brandon identifies instances when consent is not required and motivates his reasons as follows:

"There are, however, cases where adult patients cannot give or refuse their consent to an operation or other treatment. One case is where, as a result of an accident or otherwise, an adult patient is unconscious and an operation or other treatment cannot be safely delayed until he or she recovers consciousness. Another case is where a patient, though adult, cannot by reason of mental disability understand the nature or purpose of an operation or other treatment. The common law would be seriously defective if it failed to provide a solution to the problem created with such inability to consent. In my opinion, the common law does provide a solution to the problem. With the common law principles a doctor can lawfully operate on, or give other treatment to, adult patients who are incapable, for one reason or another, of consenting to his doing so, provided that the operation or other treatment concerned is in the best interests of such patients. The operation or other treatment will be in their best interests if, but only if, it is carried out in order either to save their lives or to ensure improvement or prevent deterioration in their physical or mental health." ²³²

Lord Goff in the same case endorsed the famous principle enunciated by an American Judge Cardozo J in *Schloendorff v Society of New York Hospital* 211 NY 125 (1914) 12:

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body."

The patient's right to autonomy was also recognised in a later decision namely:

In *Potts v North West Regional Health Authority* ²³³ the plaintiff was injected with 'Depo-Provera', a long-lasting and slow-acting contraceptive drug, without her prior consent at the same time as she was given a rubella vaccination, shortly after the birth of a baby. She was awarded \$3,000 damages for assault and battery because she had never been given the opportunity to accept or refuse the treatment. The judge said: 'To deprive her of the right to choose is to deprive her of the basic human right to do with her body as she wishes.' For the defendant to be successful with the defence of *volenti non fit iniuria* the defendant must show that the plaintiff consented to the medical treatment and/or surgery. To be successful however, it must be shown that the patient's consent was valid consent, often referred to as real consent. This was the position enunciated in *Chatterton v Gerson*: ²³⁴

²³² *F v West Berkshire Health Authority* (1989) 2 ALL ER 545, (1990) 2 AC 1, (1989) 2 WLR 938.

²³³ (1983) as discussed by Harpwood (1987) 388.

²³⁴ (1981) QB 432.

"In my judgement what the court has to do in each case is to look at all the circumstances and say: "Was there a real consent?" I think justice requires that in order to vitiate the reality of consent there must be a greater failure of communication between doctor and patient than that involved in a breach of duty if the claim is based on negligence."

The court goes on to state:

" once the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real, and the cause of the action on which to base a claim for failure to go into risks and implications is negligence, not trespass. " ²³⁵

As to how much detail the physician is to impart to his or her patient, in English law, patients are not entitled to the fullest possible information about the treatment they receive. Instead it is up to the doctor to decide how much information to give, and the test to be applied in deciding whether a doctor has acted reasonably in the amount of information given, is that in *Bolam v Friern Hospital Management Committee* ²³⁶ in which the court see the following criteria:

"If a doctor is able to demonstrate that he acted in accordance with a responsible body of medical opinion he will not be negligent. " ²³⁷

The dilemma of how much the doctor should, or should not, tells his patient reached trial in *Sidaway v Board of Governors of Bethlem Royal Hospital and Maudsley Hospital*. ²³⁸ The patient averred *inter alia* that she had not been told of the possibility of cord damage. She argued that if she had been told, she would not have consented to the operation and the damage would not have occurred. This raised the question of whether it was negligent to fail to warn her of the risk.

When the case reached the trial the medical witnesses for the defence said that they too would not have disclosed the risk. They justified this on the basis the risk was very slight and to mention it would probably have frightened the patient into refusing the operation. Even though the experts for the plaintiff may well have asserted that they would have told her, the defence experts represented a responsible body of medical opinion that would have withheld the information.

²³⁵ *Chatterton v Gerson* (1981) QB 432 at 443.

²³⁶ (1957) 2 ALL ER 118, (1957) 1 WLR 582.

²³⁷ *Bolam v Friern Hospital Management Committee* (1957) 2 ALL ER 118 (1957) 1 W.L.R. 582.

²³⁸ (1985) 2 WLR 480.

The House of Lords held that a doctor is not negligent in obtaining a patient's consent if he only discloses the risks which would have been mentioned by a responsible body of medical opinion when it followed the Bolam decision in which it was stated:

"A medical man is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular act ... merely because there is a body of opinion that takes a contrary view."

But the court held:

" A doctor [is] under a duty to provide the patient with the information necessary to enable the patient to make a balanced judgement in deciding whether to submit to that treatment." ²³⁹

The obligation to disclose information to the patient, in non-therapeutic cases, in England also received the court's attention.

In *Gold v Haringey Health Authority* ²⁴⁰ the plaintiff alleged *inter alia* that the consultant had been negligent in failing to discuss the treatment policy in that he had failed to explain the risk of failure and that he had not discussed any alternative method by which steps could be taken to avoid becoming pregnant. All the medical witnesses said that they would have warned the patient of the risk of failure, but that a sizeable proportion of doctors (estimated at up to 50 percent) would not have done so at the time when she had the operation.

The court followed the *Sidaway decision* although the latter cases were applicable to therapeutic procedures. Lloyd L.J. stated:

"The principle does not depend on the context in which any act is performed, or any advice given. It depends on a man professing skill or competence in a field beyond that possessed by the man on the Clapham omnibus. If the giving of contraceptive advice required no special skill, then I could see an argument that the Bolam test should not apply. But that was not, and could not have been, suggested. The fact (if it be the fact) that giving contraceptive advice involves a different sort of skill and competence from carrying out a surgical operation, does not mean that the Bolam test ceases to be applicable. It is clear from Lord Diplock's speech in Sidaway that a doctor's duty of care in relation to diagnosis, treatment and advice, whether the doctor is a specialist or general practitioner, is not to be dissected into its component parts. To dissect a doctor's advice into that given in a therapeutic context and that given in a contraceptive context would be to go against the whole thrust of the decision of the majority of the House of Lords in that case. So I would reject the argument of counsel for the plaintiff under this head, and hold that the judge was not free, as he thought, to form his own view of what warning and information ought to have been given, irrespective of any body or responsible medical opinion to the contrary." ²⁴¹

Where the patient asks questions, although there is an obligation on the doctors to disclose

²³⁹ *Sidaway v Board of Governors of Bethlem Royal Hospital and Maudsley Hospital* (1985) 2 WLR 480.

²⁴⁰ (1987) 2 ALL ER 888, (1988) 1 QB 481, (1987) 3 WLR 649, (1988) 1 FLR 55.

²⁴¹ *Gold v Haringey Health Authority* (1987) 2 ALL ER 888, (1988) 1 QB 481; (1987) 3 WLR.

information, their duty of disclosure is not unlimited. In this regard Kerr L.J. in *Blyth v Bloomsbury Health Authority*²⁴² the court of appeal criticising the comments of the Judge in the court a quo stated:

"In the light of these comments I conclude that the judge was in error in holding that there was any obligation to pass on to the plaintiff all the information available to the hospital; that is to say in this case the information contained in Dr Law's files. That conclusion could not properly be based upon the evidence. As regards the judge's repeated reference to the need to give a full picture in answer to a specific enquiry, it must be borne in mind, apart from the other matters already mentioned in that regard, that no specific enquiry was found to have been made in this case.

*Secondly, I think the judge's conclusions equally cannot properly be based on the remarks of Lord Diplock and Lord Bridge in Sidaway. The question of what a plaintiff should be told in answer to a general enquiry cannot be divorced from the Bolam test, any more than when no such enquiry is made. In both cases the answer must depend upon the circumstances, the nature of the enquiry, the nature of the information which is available, its reliability, relevance, the condition of the patient, and so forth. Any medical evidence directed to what would be the proper answer in the light of responsible medical opinion and practice - that is to say, the Bolam test - must in my view equally be placed on the balance in cases where the patient makes some enquiry, in order to decide whether the response was negligent or not."*²⁴³

More recent decisions have however started questioning the conservatism display by the court in the decisions of *Sidaway* and *Blyth*. In *Smith v Tunbridge Wells Health Authority*²⁴⁴ referring to the Bolam judgement Morland J concluded:

"In my judgement by 1988, although some surgeons may still not have been warning patients similar in situation to the plaintiff of the risk of impotence, that omission was neither reasonable nor responsible.

*In my judgement Mr Cook, in stating that he considered that he owed a duty to warn, was reflecting not only the generally accepted standard practice, but also the only reasonable and responsible standard of care to be expected from a consultant in Mr Cook's position faced with the plaintiff's situation."*²⁴⁵

7.3.1.2.3 Legal Opinion

- (1) The doctrine of *volenti non fit iniuria* is a recognised defence in England in a general, as well as in a medical context and plays a significant role in the English Law of Tort.²⁴⁶
- (2) The rationale for the existence of the doctrine of *volenti non fit iniuria*, in a general

²⁴² (1993) 4 Med. L.R. 151.

²⁴³ *Blyth v Bloomsbury Health Authority* (1993) 4 Med. L.R. 151.

²⁴⁴ (1994) 5 Med. L.R. 334.

²⁴⁵ *Smith v Tunbridge Wells Health Authority* (1994) 5 Med. L.R. 334.

²⁴⁶ Milner *Negligence in Modern Law* (1967) 99; Rogers Winfield and Jolowicz on *Tort* (1989) 691; Street *The Law of Torts* (1993) 82-83; Jackson and Powell *Professional Negligence* (1997) 317; Kennedy and Grubb *Principles of Medical Law* (1998) 171; Mason and McCall-Smith *Law and Medical Ethics* (1987) 120; Skegg *Law, Ethics and Medicine* (1984) 88; Scott *The General Practitioner and The Law of Negligence* (1995) 91.

sense, stems from a philosophical premise, namely; the freedom to choose between alternatives coupled with the social outlook that each man is master of his fate and the best judge of his own wellbeing. Hence, where consent is given involving the risk of harm, the party consenting cannot be heard to say afterwards that he has been wronged as no wrong is done to a willing party.²⁴⁷

- (3) Consent is an integral part, therefore, of the doctrine of *volenti non fit iniuria*. Especially in a medical context, in that, where a physician carries out treatment of a patient and/or performs an operation on a patient without the necessary consent, the patient may sue the physician for damages.²⁴⁸
- (4) Before however, consent may successfully be invoked; certain requirements must first be met before one can talk of real consent inter alia:
- (4)(1) The physician has a duty to provide the patient with sufficient information regarding the risks of medical procedure including treatment and/or operations.²⁴⁹
- (4)(2) As to what constitutes sufficient information, the English writers, have identified various factors which influence how much information is expected to be given by the physician to the patient, which include, the patient's capability to understand the nature and scope of the medical treatment, the patient's desire for information, the nature and scope of the proposed treatment and/or surgical procedure and the effect of the information on the patient.²⁵⁰

²⁴⁷ Milner *Negligence in Modern Law* (1967) 99; Rogers Winfield and Jolowicz on *Tort* (1989) 691; Street *The Law of Torts* (1993) 82-83; Jackson and Powell *Professional Negligence* (1997) 317; Kennedy and Grubb *Principles of Medical Law* (1998) 171; Mason and McCall-Smith *Law and Medical Ethics* (1987) 120; Skegg *Law, Ethics and Medicine* (1984) 88; Scott *The General Practitioner and The Law of Negligence* (1995) 91.

²⁴⁸ Street *The Law of Torts* (1993) 82; Rogers Winfield and Jolowicz on *Torts* (1989) 682-683; Skegg *Law, Ethics and Medicine* (1984) 88; Mason and McCall-Smith *Law and Medical Ethics* (1987) 120; Scott *The General Practitioner and The Law of Negligence* (1995) 88-89; Kennedy and Grubb *Principles of Medical Law* (1998) 215ff. For case law see *F v West Berkshire Health Authority* (1989) 2 ALL ER 545 (1990) 2 AC 1 (1989) 2 WLR 938; *Potts v North West Regional Health Authority* (1983) as discussed by Harpwood *Principles of Tort Law* (1997) 388.

²⁴⁹ Skegg *Law, Ethics and Medicine* (1984) 88; Mason and McCall-Smith *Law and Medical Ethics* (1987) 120; Rogers Winfield and Jolowicz on *Tort* (1989) 685; Street *The Law of Torts* (1993) 82; Scott *The General Practitioner and the Law of Negligence* (1995) 88-89; Kennedy and Grubb *Principles of Medical Law* (1998) 171. For case law see *Chatterson v Gerson* (1981) QB 432.

²⁵⁰ Skegg *Law, Ethics and Medicine* (1984) 88-92; Mason and McCall-Smith *Law and Medical Ethics* (1987) 120; Rogers Winfield and Jolowicz on *Tort* (1989) 685; Street *The Law of Torts* (1993) 82; Scott *The General Practitioner and The Law of Negligence* (1995) 88-89; Kennedy and Grubb *Principles of Medical Law* (1998) 171. For case law see *Bolam v Friern Hospital Management Committee* (1957) 2 ALL ER 118 (1957) 1 WLR 582; *Sidaway v Board of Governors of Bethlem Royal Hospital* 1985 2 WLR 480; *Gold v Haringly Health Authority*

- (4)(3) But England, unlike America, does not recognise "Informed Consent". As long as the patient understands the broad nature of what is to be done, his consent is not vitiated by failure to explain in detail the risks inherent in the procedure.²⁵¹
- (5) Although at Common Law in England, in the absence of duress or some other vitiating factor, entry into a contract exempting the defendant from liability for negligence was a complete defence, notwithstanding the plaintiff not having troubled to read the terms. Once the contracting party signed the agreement with the excluding term forming part of the contract, he/she was bound by the agreement. However, with the promulgation of the Unfair Contract Terms Act of 1977, limitations have been placed on contractual freedom in that contracting parties are no longer, by reference to any contract, free to exclude or restrict their liability for death or personal injury resulting from negligence.²⁵²
- (6) In so far as voluntary assumption of risk as defence in a medical context is concerned, although I did not come across case law on the point *in casu*, nevertheless, the same statutory restriction which is placed on the parties freedom to agree in instances in which the maxim of *volenti non fit iniuria* may not successfully be invoked, are also applicable in instances where the physician and the patient have reached an express agreement that the plaintiff will voluntarily assume the risk of harm.²⁵³

7.3.1.3 UNITED STATES OF AMERICA

7.3.1.3.1 Legal Writings

Although some of the legal writers have recognised the doctrine of *volenti non fit iniuria* as a fundamental principle of the common law,²⁵⁴ most writers, with reference to the

(1987) 2 ALL ER 888, (1988) 1 QB 481, 1987 3 WLR. 649; *Blyth v Bloomsberg Health Authority* (1992) 4 MED L.R. 151; *Smith v Tunbridge Wells Health Authority* (1994) 4 MED L.R. 334.

²⁵¹ Rogers Winfield and Jolowicz on *Tort* (1989) 685; Robertson "Informed Consent to Medical Treatment" (1981) 97 *L.Q.R.* 102. For case law see *Chatterton v Gerson* (1981) QB 436; *Hills v Potter* (1984) 1 WLR 641; *Sidaway v Bethlem Royal Hospital* (1985) AC 871.

²⁵² S.2 (1) of the Unfair Contract Terms Act 1977.

²⁵³ The restriction is placed by S2 (1) S2 (3) of The Unfair Contract Terms Act 1977. See Harpwood *Principles of Tort Law* (1997) 110.

²⁵⁴ Prosser and Keeton *The Law of Torts* (1971) 112; Bohlen "Consent as Affecting Civil Liability for Breaches of the Peace" 1924 24 *Col.L. Nev.* 819.

recognition of a defence against medical negligence involving consent, have preferred the defence of assumption of risk, which may, in certain circumstances, be invoked by the physician.²⁵⁵

The doctrine of assumption of risk is said to blend into the issue of informed consent and waivers of liability.²⁵⁶ Assumption of risk entails that the patient, notwithstanding, his/her knowledge and understanding of possible harmful consequences which certain treatment and/or surgery may hold for him/her, nevertheless, consents to the treatment and/or surgery.²⁵⁷

The doctrine of assumption of risk is said to be founded upon the general law which recognises that an individual is free from unwarranted and unwanted intrusion, since it extends the patient's decision-making power, even to choose unconventional therapies.²⁵⁸

For the doctrine to be successfully invoked, it has often been said that the principles applicable to informed consent must first be complied with, *inter alia* the physician must first carry out his duty towards the patient, namely, to disclose certain information about risks collateral to the proposed therapy and secondly, the physicians must not proceed, without consent, to the risks that have been, or should have been, disclosed.²⁵⁹

The concept "consent" therefore involves knowledge and understanding, as well as a duty on the physician to carefully explain to the patient the proposed treatment and/or surgery and the risks attached thereto. For that reason it has often been stated that the doctrine of "Assumption of Risk" is related to informed consent.²⁶⁰

²⁵⁵ Furrow et al *Health Law* (1995) 256; Bianco and Hirsh "Consent to and Refusal of Medical Treatment" A chapter in *American College of Legal Medicine Legal Medicine* (1991) 286; Holder *Medical Malpractice Law* (1975) 306; Southwick *The Law of Hospital and Healthcare Administration* (1988) 72.

²⁵⁶ Furrow et al (1995) 256; Holder (1975) 225.

²⁵⁷ Holder (1975) 310; Sharter and Plant *The Law of Medical Malpractice* (1959) 154; Bianco and Hirsch (1991) 286; Southwick and Slee (1988) 72.

²⁵⁸ Furrow et al (1995) 256; Flamm "Healthcare Provider as a Defendant" A chapter in *American College of Legal Medicine Legal Medicine* (1991) 120; Prosser and Keeton (1971) 112.

²⁵⁹ Waltz and Inbau (1971) 156; Bisbing McMenami Granville "Competency, Capability and Immunity" A chapter in *American College of Legal Medicine* (1991) 121; Flamm "Healthcare Provider as a Defendant" A chapter in *American College of Legal Medicine* (1991) 120; Holder (1975) 227; Peters (1981) 163-164; Moore and Kramer *Medical Malpractice: Discovery and Trial* (1990) 35-36; Southwick and Slee (1988) 361ff; Pozgar and Pozgar (1996) 395-396.

²⁶⁰ See Holder (1975) 306; See also Bianco and Hirsh (1991) 286; Furrow et al (1995) 256; See further Southwick and Slee (1988) 72.

The effect of the closeness of the inter-relationship between the two doctrines amounts to this, where the physician fails to fully inform the patient of the intended treatment and/or operation to the extent that the patient is apprised of all the risks which he or she may encounter, so much so, that the patient understands the risks, it cannot be said that the patient properly exercised informed consent.

This may result in the physician being held liable for negligence, in that, without clear proof of totally informed consent; the defence of assumption of risk will be unsuccessful.²⁶¹

The defence of assumption of risk will also be unsuccessful where the physician's diagnosis or treatment fall below the expected standard of due care. Put differently, it has been stated before, that the defence of assumption of risk does not apply to cases of negligence. If, therefore, the physician advises the patient of the risks of proper care and then provides improper care, he/she cannot successfully invoke the defence on the ground that the patient has assumed the risk.²⁶²

Waivers of liability and other attempts at exculpating healthcare providers from liability have, as with assumption of risk and negligence, been treated with disdain by the American legal writers.²⁶³ It appears, therefore, that the general consensus amongst the writers is that physicians and hospitals ought not to contract out of negligence.

For a more in-depth discussion see Chapter 4 *infra*.

7.3.1.3.2 Case Law

The American courts have in the past recognized the express assumption of risk as a defence.

The case of *Shorter v Drury*²⁶⁴ involved such a case which stemmed *inter alia* from the refusal of a Jehovah's Witness to accept a blood transfusion. In this case the decedent became pregnant and consulted the defendant physician who determined the foetus had died. The physician recommended removal of the foetus by dilation and curettage which

²⁶¹ Holder (1975) 226-227, Waltz and Inbau (1971) 164ff; Flamm (1991) 121; Moore and Kramer (1990) 35-36; Pozgar and Pozgar (1996) 395-396; Southwick and Slee (1988) 361ff.

²⁶² Holder (1975) 307-308; Southwick and Slee (1988) 72.

²⁶³ Furrow et al (1995) 257. Holder (1975) 716.

²⁶⁴ 103 WASH 2d 645, 695 P.2d 116 (1985).

involved a risk of bleeding. He described this procedure to Mr and Mrs Shorter, advising them of the possibility of bleeding, but no other methods were discussed with them. Immediately prior to the procedure, Mrs Shorter signed a consent which expressly released the hospital for any injuries resulting from her refusal to accept a blood transfusion. During the operation she began to bleed due to lacerations caused by Dr Drury. Although she continued to bleed profusely, while still coherent she refused to authorize a transfusion despite warnings that she would die. Mrs Shorter ultimately bled to death, and expert witnesses for both parties agreed a blood transfusion would have saved her life.

The Washington Supreme Court upheld the validity of the release signed by Mrs Shorter. It further held that the release precluded the cause of action arising from Dr Drury's negligence where the injury resulted from Mrs Shorter's refusal to accept blood.

In *Schneider v Revici*²⁶⁵ the court also recognized the viability of the defence of express assumption of risk. This case arose from the treatment of breast cancer with an unconventional form of treatment. Dr Revici operated a clinic which specialized in experimental therapies. After Mrs Schneider signed a lengthy consent form, Dr Revici diagnosed her cancer and began treating it with selenium and a special diet. After 14 months of treatment, when the tumour had increased in size and spread to the other breast and lymph nodes, Mrs Schneider finally underwent a bilateral mastectomy.

In its decision the court focused on an alleged covenant not to sue executed by Mrs Schneider. It noted that New York federal law recognises the efficacy of a covenant not to sue in the context of experimental and inherently dangerous medical procedures. New York law also required that the covenant to sue be strictly construed against the drafting party, and that its wording be clear and unequivocal. But the court concluded the form signed by Mrs Schneider lacked the precision required by New York law.

In the case of *Mainfort v Giannestras*²⁶⁶ a diabetic patient was warned, in advance of surgery, that his condition might result in an unavoidable infection. He told the physician that he wished to proceed. His leg had to be amputated as a result of post-operative infection. It was held that he had assumed the risk.

In the following cases the courts also upheld the defence of express voluntary of risk. In

²⁶⁵ 817 F.2d 987 (2d CIR. 1987).

²⁶⁶ 111 NE 2d 692, OHIO 1951.

the first case, of *Gramm v Boesner*,²⁶⁷ decided as far back as 1877, the facts were as follows: a man fractured his arm and the defendant set it. Some weeks later it was apparent that the bones were slightly out of alignment. There was no clear indication whether the original setting of the fracture had been negligent or whether the bones had been displaced through no fault of the surgeon. The patient asked the defendant to operate on the arm, break it, and reset it. The defendant opposed the suggestion because he thought this would be bad medical practice, but he eventually agreed. The outcome of the second operation was far worse than the original misalignment.

The court held in favour of the surgeon and said that if a physician tells a patient that an operation is improper and advises against it and the patient still insists upon it, the patient assumes the risk because he relies upon his own judgement and not that of the surgeon.

The facts in the second case of *Brockman v Harpole*²⁶⁸ were as follows:

An adult patient had had his ears washed out on several occasions because they became plugged with wax. He came to the office of his physician without an appointment and told a nurse that he wanted his ears washed out. He was told that both physicians who practised in the office were at the hospital and that his ears could not be treated until one of the physicians could examine him and order such a procedure. He insisted that the nurse do it without requiring him to wait for the physician's return and she finally agreed to do so. During the washing process, both his eardrums were ruptured.

The court held that the fact that the patient came to the office without an appointment and persuaded the nurse, against her better judgement, to perform the procedure without waiting for an examination by a physician was sufficient to support a finding that he had assumed the risk.

In another case of *Karp v Cooley*,²⁶⁹ the surgeon was not held liable for the patient's death after a heart transplant because he had fully informed the patient and obtained consent to the operation.

In so far as an implied assumption of risk is concerned, the American courts, in a number of cases, recognised the doctrine as a defence, despite the plaintiff not agreeing expressly to

²⁶⁷ 56 TOND 497, 1877.

²⁶⁸ 444 P2d 25, ORE 1968.

²⁶⁹ 349 F.Supp. 827 (S.D.TEX.1972) Aff.1 493 F.2d 408.

assume the risk. In this regard, in the case of *Charrin v Methodist Hospital*,²⁷⁰ the plaintiff assumed the risk of injury when she tripped over a television antenna cord in her hospital room. She knew of the cord's existence, as she had earlier pointed out its dangers.

In *Causey v Dean*²⁷¹ a patient who voluntarily submits to treatment, depending entirely on the surgeon to decide what shall be done, gives a general consent by implication for such operation as may, in the surgeon's professional judgement, be reasonably necessary.

In a number of cases the American courts refused to uphold the defence of assumption of risk and relied especially on two overriding factors, namely; the hospital performing activities thought suitable for public regulation, as well as the unequal bargaining power of the hospital in the negotiation of hospital-patient contracts. The leading case in this regard is that of *Tunkle v Regents of University of California*,²⁷² in which the court held invalid a release from liability for future negligence which was imposed as a condition of admission to a charitable hospital. The court noted the decisive advantage in bargaining power on the part of the hospital, and characterized the release as an adhesion contract. It also noted that the hospital was providing an essential and crucial public service.

Likewise, in *Abramowitz v New York University Dental Centre, College of Dentistry*²⁷³ the court struck down a poorly drafted release which had been buried in a lengthy registration form.

The American courts have also rejected the defence of implied assumption of risk where it was not proved that the plaintiff possessed the necessary knowledge and appreciation of the risk involved. In the case of *Reyes v Wyeth Labs*²⁷⁴ the court held that the mother of

²⁷⁰ 432 S.W.2d 572 (TEX. APP.1968).

²⁷¹ 280 So.2d. 251 (LA.1973).

²⁷² 60 CAL.2d 92, 383 P.2d 441, 82 CAL.RPTR.33 (1963).

²⁷³ 110 A.D. 2d 343; 494 N.Y.S.2d 721 (1985); See also *Porubiansky v Emory Univ.* 156 Gs.App.602, 275 S.E. 2d 163 (1980). In an action against a dentist and a dental school, the court voided an exculpatory clause in the patient's consent form. The practice of dentistry was suitable for public regulation and already was regulated by statute. Moreover, the relative positions of the dentist and patient were unequal. See also *Olson v Molzen* 558 S.W.2d 429 (Tenn.1977). An exculpatory agreement between a doctor and a patient signed as a condition to receiving to abortion was contrary to public policy. The doctor occupied a superior bargaining position in relation to the patient. See further *Smith v Hosp. Auth. of Walker* 160 Gs.App.387, 287 S.E. 2d 89 (1981). The court held that a release by a prospective blood donor prior to extraction of blood, absolving all medical personnel from liability for negligence, was void against public policy.

²⁷⁴ 498 F.2d 1264 5th Cir. 1974, Apply in Texan law.

an infant who was given a polio vaccine that was "unavoidably unsafe" did not assume the risk of injury if she was unaware of the danger inherent in the vaccine.

In the case of *Los Alamos Med. Center v Coe* ²⁷⁵ the court rejected both the "assumption of risk" and "contributory negligence" defences. In this case, the plaintiff received repeated injections of morphine during home treatment for relatively minor complaints. Although the defendant became aware that she took the drug more out of desire and dependency than from a genuine need for relief from pain, this awareness did not constitute the kind of voluntary participation required for assumption of risk or contributory negligence.

7.3.1.3.3 Legal Opinion

- (1) Although the doctrine of *volenti non fit iniuria* is recognised as a fundamental principle of the common law, ²⁷⁶ the defence mostly preferred by the American legal writers and the courts alike, involving medical negligence, in which consent plays a dominant role, is that of assumption of risk. ²⁷⁷
- (2) The doctrine of assumption of risk is said to blend into the issue of informed consent and waivers of liability. ²⁷⁸
- (3) The doctrine entails that the patient, notwithstanding his/her knowledge and understanding of the possible harmful consequences which certain treatment and/or surgery may hold for him, nevertheless, consent to the treatment and/or surgery. The effect of such consent is that the physician, if sued for damages arising from his/her negligence, may invoke the defence of "assumption of risk" and avert liability based upon the fact that the patient relied upon his/her own judgement. ²⁷⁹

²⁷⁵ 58 N.M.686 275 P.2d 175 (1954).

²⁷⁶ Prosser and Keeton *The Law of Torts* (1971) 112; Bohlen "Consent as affecting civil liability for breaches of the Peace" 1924 24 *COLL. New* 819.

²⁷⁷ Furrow et al *Health Law* (1995) 256; Bianco and Hirsh "Consent to and refusal of medical treatment" A chapter in *American College of Legal Medicine* (1991) 288; Holder *Medical Malpractice Law* (1975) 306; Southwick *The Law of Hospital and Healthcare Administration* (1988) 72.

²⁷⁸ Furrow et al *Health Care* (1995) 256; Holder *Medical Malpractice Law* (1975) 225. For case law see *Shorter v Drury* 103 ASH 2d 645, 695 P 2d 116 (1985); *Schneider v Revici* 817 F. 2d 987 (2d CIR 1987); *Mainfort v Giannestras* 111 NE 2d 692 OHIO 1951; *Cramm v Boesner* 56 TOND.497 1877; *Brochman v Harpole* 444 P 2d 25, ORE 1968; *Karp v Cooley* 349 F. Supp. 827 (S.D. TEX 1972) AFF 1 493 F. 2d 408.

²⁷⁹ Holder *Medical Malpractice Law* (1975) 310; Sharter and Plant *The Law of Medical Malpractice* (1959) 154; Bianco and Hirsh "Consent as affecting civil liability for breaches of the Peace" (1991) 286; Southwick and Slee *The Law of Hospital and Healthcare Administration* (1988) 72 *Gramm v Boesner* 56 TOND. 497 1877; *Shorter v Drury* 103 WASH 2d 645, 699 P.2d 114 (1985); *Schneider v Revici* 817 F. 2d 987 (2d CIR. 1987); *Mainfort v Giannestras* 111 NE 2d 692, OHIO 1951; *Karp v Cooley* 349 Supp 827 (S.A.je x 1972) Aff. 1 473 f 2D 408.

- (4) For the defence to be successful however, the following requirements must first be met *inter alia*:
- (4) (1) The principles applicable to informed consent, namely; the disclosure of certain information about risks collateral to the proposed therapy, must first be impacted by the physician, to the patient, in order for the patient to make an informed decision and secondly, the patient's consent, to the risks explained, must be forthcoming.²⁸⁰
- (4) (2) The physician's diagnosis or treatment, notwithstanding the patient's consent, must not fall below the expected standard of due care. In other words, the physician cannot contract out of negligence.²⁸¹
- (5) Waivers of liability and other attempts at exculpating healthcare providers from liability, as with assumption of risk and negligence, have received a negative response from both the American legal writers and the courts. Various factors militate against their validity when incorporated in agreements, which include the vulnerability of the patients, the anxious state patients find themselves in upon admission, the unequal bargaining position of the parties, the effect of his/her own negligence.²⁸²

7.4 Summary and Conclusions

It is evident from the discourse in this Chapter, that the different jurisdictions, selected for the research undertaken in this thesis, do recognize certain defences which serve as grounds of justification and which limit, or exclude, the liability of a person/persons/or institutions arising from their conduct which caused damages, which, in the absence of such defences, would otherwise have been regarded as tortuous or delictual conduct.

²⁸⁰ Waltz and Inbau *Medical Jurisprudence* (1971) 156; Bisber, McMenamin, Granville "Competency, capability, and immunity" A chapter in *American College of Legal Medicine* (1991) 121; Flamm "Healthcare provider as a Defendant" A chapter in *American College of Legal Medicine* (1991) 121.

²⁸¹ Holder *Medical Malpractice Law* (1975) 307-308; Southwick and Slee *The Law of Hospital and Healthcare Administration* (1988) 72.

²⁸² Furrow et al *Health Law* (1975) 257; Flamm "Healthcare provider as a Defendant" A chapter in *American College of Legal Medicine Legal Medicine* (1991) 121; Holder *Medical Malpractice Law* (1975) 316. For case law see *Tunkle v Regents of University of California* 60 CAL 2d 92, 383 P 2d 441, 82 CAL RPTR 33 (1963); *Abramowitz v New York University Dental Centre, College of Dentistry* 110 A.D. 2d 343; 494 NYS 2d 721 (1985); *Porubiansky v Emory University* 156 69 APP 602 275 SE 2d 163 (1980); *Olsen v Molzen* 558 S.W. 2d 429 (TENN 1977); *Smith v Hospital Authority of Walker* 160 69 APP 387 287 S.E. 2d 89 (1981).

One of the defences is that of *volenti non fit iniuria*, which means that no harm is done to someone who consents thereto. Consent in the doctor/hospital/other healthcare provider contractual relationship plays a foundational role, which has the effect that the presence of consent indicates that an act which is *prima facie* actionable, assures the plaintiff of the right afterwards to complain of it. But, before it can be said that the defence of *volenti non fit iniuria* is legally operative, certain requirements must first be met, *inter alia*, that the consent given must be recognised by law i.e., it must conform with the dictates of society, the so-called *boni mores*. This requirement is of great importance to the core of this thesis, as well whether a doctor/hospital/other healthcare provider may validly include in a written agreement with a patient, a term releasing him/her/it from any legal obligation to show due skill and care, for such conduct? Put in the alternative, whether a patient's consent releasing a doctor/hospital/other healthcare provider from a legal obligation to show due skill and care, would not be used against public policy?

Two of the mainstream defences, recognised by the different jurisdictions in South Africa, England and the United States of America, include the doctrine of *volenti non fit iniuria* and the assumption of risk. The main purpose for the existence of the defences in the general law sphere is said to lie in the fact that no man can complain of an act which he/she has expressly or impliedly consented to. The effect thereof is that the defendant finds himself/herself exonerated from liability, or put differently, relieved of a legal duty to the plaintiff. The rationale underlying the defences is based on the jurisprudential principle of individualism, in that the individual is left to work out his/her own destiny. To this end, a person who willingly consents to the defendant's act, in the form of either a specific harmful act or an activity involving a risk of harm, cannot complain that a wrong has been committed against him or her.

The discourse in this Chapter reveals that the application of these defences, in the general sphere, is not without any restriction or limitations. For the maxim *volenti non fit iniuria* to succeed certain requirements, *inter alia* consent, must be present and which must be real consent. For consent to be real it is required that the consenting party must have had knowledge and been aware of the nature and extent of the harm or risk. Furthermore, its use must be recognised by law and not regarded as *contra bonos mores*. As to when or under what circumstances consent would be regarded as *contra bonos mores*, regard must be had to the prevailing convictions of the community. It is also clear from the discussion in this Chapter that the following factors sway the legal convictions of the community, namely, the nature and extent of the interest involved the motives of the parties and the social purpose of the consent or assumption of risk. Another factor, which has also

influenced societal conviction, is the so-called 'contracting out of liability' cases in which some courts and legal writers alike have viewed such conduct to be grossly unprofessional, void as against public policy.

In the South African and United States of America jurisdictions, the restrictions or limitations to the said defences are regulated by the common law. In England however, the English Unfair Contract Terms Act 1977 impacts on these defences.

From the discourse in this chapter it is also clear that the bargaining position of the parties to an agreement may also influence the restriction or limitation placed on consent, which results in such conduct to be against public interest or public policy. As far as the question of the general application of the defence of "voluntary assumption of risk" in dependants' claims is concerned; this seems to be fairly settled in the different jurisdictions. Today the position seems to be that as the dependants have an independent, non-derivative right, defences such as waiver of action or voluntary assumption of risk, which would have negated the breadwinner's claim for injuries had he/she lived, will not avail against the dependants. Besides the common law protection, constitutionally, the South African Constitution, Act 108 of 1996 also bestows a duty on parents, guardians or wards to act in the best interests of minors. Signing a waiver or consenting to the voluntary assumption of risk cannot be said to be acting in the best interest of the child.

This chapter also focused on the edictal position with regard to the validity of the defence of *violent non fit injuries* as a ground of justification for medical interventions. It is clear from this chapter that, whereas the South African and English jurisdictions recognise the defence of *violent non fit injuries* as a ground of justification for medical interventions, the United States of America prefer the doctrine of assumption of risk as a defence.

But it is clear from the discourse in the chapter that the application of the maxim, *violent non fit injuries*, may only be raised successfully as a defence provided it is shown that certain requirements had been met. The requirements include that the patient had sufficient knowledge of the procedure to be followed and he/she appreciated the consequences; and nevertheless consented thereto. Similarly, as with the application of the defence in the general sphere, the consent given must be recognized by law. Once again the dictates of society play a fundamental role in determining whether consent has been validly given.

It is especially, in the so-called 'contracting out of liability' cases, in which a patient consents not to sue a doctor/hospital/other healthcare providers, that many South African writers have persuasively argued that notwithstanding the fact that consent was given, it

does not conform with the dictates of society, the so-called *boni mores*. This school of thought argues that no medical practitioner/hospital should be released from his/her/its obligation to show due skill and care, for such conduct would be grossly unprofessional and void as against public policy. Other factors influencing their thinking include the unequal bargaining position the patient occupies in relation to, especially, the medical practitioner/hospital who stand in a superior bargaining position; the position of trust the doctor/hospital occupies in relation to the patient; the fiduciary relationship between the medical practitioner/hospital and the patient; the influence of normative ethics and other ethical codes, medico-legal considerations and constitutional demands. Another school of thought that holds an opposing view is greatly influenced by the doctrine of freedom of contract. They argue that once the contracting parties consent, they should not afterwards be heard to complain against their own folly and rely heavily on the *caveat subscriptor* rule. This view seems to have found favour with the South African courts, more particularly, the Supreme Court of Appeal, who in the case of *Afrox Healthcare Bpk v Strydom* decided, contrary to popular opinion, that exclusionary clauses in hospital contracts are not against public policy. This controversial issue forms the subject matter of the central theme of this thesis and will be the subject of a comprehensive discussion in Chapter 14.

It is also clear from the discussion in this chapter that in the English jurisdiction the doctrine of *volenti non fit iniuria* is recognized as a defence, in a medical context, provided certain requirements are first met. But, the defence is not unlimited as legislative restrictions are placed which limit contractual freedom. In terms of the Unfair Contract Terms Act 1977, a medical practitioner/hospital is not free to exclude or restrict his/her/its liability for death or personal injury from negligence. The same principle applies when a medical practitioner/hospital and the patient have reached an express agreement that the plaintiff will voluntarily assume the risk of harm.

In this chapter it is also seen that the doctrine of assumption of risk is preferred to *volenti non fit iniuria* as a defence in a medical context. But, as in the other jurisdictions where the doctrine of *volenti non fit iniuria* is preferred, certain requirements first have to be met before the defence of assumption of risk will succeed. But, the defence does not operate without limits or restrictions in that despite consent, the defence will be unsuccessful where the medical practitioner's/hospital's conduct falls below the expected standard of due care and skill. It follows therefore, that should the medical practitioner/hospital advise the patient of the risks and then provide improper care, he/she/it will not successfully be able to invoke the defence on the ground that the patient has assumed the risk.

Likewise, the courts in America view waivers of liability and other attempts to exculpate

medical practitioners/hospitals from liability, as with assumption of risk and negligence, with disdain. Contracting out of negligence is treated as void, against public interest or *contra bonos mores* in the United States of America.

The discussions in the preceding chapters have covered the nature of the doctor-patient relationship commencing with the history of the relationship and extending to the modern day context. Having regard to the nature of the relationship, it is clear that the relationship comprises both a contractual relationship and general relationship flowing from both the contractual, as well as the general relationship, of the doctor/hospital-patient relationship as a duty of care, which set a standard of care which the doctor/patient must comply with. What was also looked at, in particular, in Chapter 7 is whether the doctor's/hospital's duty of care may be limited or excluded in a medical context. From what is discussed in Chapter 7 it follows that the doctrine of *volenti non fit iniuria* and the assumption of risk play a significant role in their application. What is also significant is the restrictions or limits placed on their applications, especially, where the convictions of the community so dictate. This discourse, albeit to a limited degree, will be foundational to the focal point of this thesis in determining whether exclusionary or exculpatory clauses in hospital contracts, exonerating medical practitioners or hospitals from liability for their negligence, may validly be included in contract.

The subsequent chapters will consider, in detail, the role of the law of contract in general and how principles including freedom of contract, the *caveat subscriptor* rule, fairness, unconscionableness and public policy influencing the law of contracts in general, impact on medical contracts. What will also be considered will be the role of exclusionary clauses in the commercial sphere and how they impact on contractual relationships? In Chapter 13 Constitutional values and principles will be considered as means to determine how they impact on contract law in South Africa. The considerations referred to hereinbefore are foundational to the ultimate chapter when the legitimacy of exclusionary clauses in medical contracts will be investigated. Consequently, a contractual law, as they relate to exclusionary clauses, is the subject of the next chapter and succeeding chapters.