Chapter 6

Law Of Contract: Health Service Delivery in the Private Sector

6.1 Introduction

In the preceding two chapters the fundamental principles of the law of contract as it related to health service delivery were discussed and the case law on this subject involving the private sector. This chapter deals with the case law relating to health service delivery in the private sector.

Contract is generally regarded in the private health care sector as the usual legal basis on which a patient obtains services from a provider. This is despite the fact that in the context of the relationship between a medical practitioner and a patient, documentation reflecting the agreement is seldom created and there is usually no negotiation of the terms between the contracting parties. The contract between provider and patient are therefore often verbal. This obviously does not detract from the validity of such contracts but it does make their terms harder to prove. Where the provider is a health care institution such as a private hospital, the agreement is more likely than not to be reduced to writing, but again there is precious little negotiation between the patient and the provider concerning its terms, even the essential terms. The question of how the constitutional rights of access to health care services and the right not to be refused emergency medical services apply in the context of the law of contract and to private sector providers of health care services has so far not been canvassed in much significance except in the case of *Strydom v Afrox Healthcare*[1] in which the arguments of the court in finding for the plaintiff were, with respect, not particularly well constructed although its finding, it is submitted, was just and effectively correct. The law of contract in South Africa seems still to be premised on business concepts, perceptions of the manner in which markets operate and the kinds of goods and services within those markets that were relevant a hundred years or more ago. At that time, people could afford to enter into litigation at the level of the High Court for non-payment of an account for dentures[2]. There are few dentists in the present day who would litigate at High Court level for non-payment for a set of false teeth since the cost of the litigation exponentially exceeds that of the teeth. One hundred years ago, the primitive ancestors of what we know as medical schemes were just beginning to take shape. One hundred years ago, organ transplants were a dream of the future and there was no such thing as renal dialysis. X-ray machines were a

1 *Strydom* (2001) 4 All SA 618 (T)

2 Whether this implies that the cost of dentures has decreased phenomenally relative to the costs of litigation or whether it means that the cost of litigation has risen phenomenally relative to the cost of a set of dentures is left to the reader to decide.

radical new technology and some people still believed that the brain was made up of thirty-seven organs, each controlling a different part of the personality[3]. One hundred years ago aspirin was formulated from salicylic and acetic acids. It was the first drug to be synthesised and its formulation is regarded as the foundation of the modern pharmaceutical industry[4]. One hundred years ago, patent medicine men roamed the countryside selling all kinds of concoctions that were supposed to cure nearly any ailment. The claims made were fantastic and the sales pitch excellent; so, naturally, people bought the concoctions. The medicine man was careful to tell people that the effect was not immediate so as not to arouse suspicion while he was still in town[5]. Faughnan and Lagace write that it is easy to forget that we have had scientific medicine only for a short time. Biomedical sciences began their great surge only sixty years ago, and the clinical sciences have gained strength only in the past twenty or thirty years. Those who would turn away from science now should first review a medical textbook from only one hundred years ago. It is filled with as many worthless remedies as any medieval text, or modern herbal[6]. One hundred years ago it was thought that a physiological basis for female insanity existed in the reproductive organs and that the obvious solution was surgery. For example, women underwent hysterectomies for "calming" purposes; the word "hysteria" is derived from the Greek word for uterus[7]. The medical world has changed considerably in the last hundred years and so, it is submitted, has the nature of health care services, their capacity to prolong or sustain life and the central role they play in our society. Diseases that were fatal to one's ancestors one hundred years ago are now little more than inconveniences thanks to the enormous advances in medical technology, skill and knowledge over the last century[8].

The law of contract in South Africa, however, seems not to have moved with the times. It does not take into account the significant sociological, economic and cultural

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3 *Medicine in America* http://library.thinkquest.org

4 Elwood PC 'Aspirin: Past, Present and Future' *Clinical Medicine Journal* JRCPL 2001; 1: p 132-137 http://www.rcplondon.ac.uk/pubs/ClinicalMedicine/02_mar_lect1.htm

5 Stump II RC 'Magnetic Water Treatment Attracts Gullible' *Newsplash* http://wwwh2otest.com/newsplash/magnet.html

6 Faughnan J G and Lagace E A 'Alternative Medicine by Family Physicians: A Contrary Perspective' http://www.faughnan.com/papers/altmedfp.html

7 Fugh-Berman A 'Alternative Healing' *Reader's companion to women's history* http://college.hmco.com/history/readerscomp/women/html/wh_001200_alternativeh.htm

8 Engel C notes in 'Healthy Intentions' that one hundred years ago, the leading causes of death in the industrial world were infectious diseases such as tuberculosis, influenza, and pneumonia. Since then, the emergence of antibiotics, vaccines, and public health controls has reduced the impact of infectious disease. http://www.firstscience.com/SITE/ARTICLES/healthy.asp

changes and challenges brought about by these advances. It does not take into account that the milieu in which health care services are nowadays delivered has changed dramatically. So far, the Supreme Court has failed to take into account even the express legal changes surrounding the delivery of health care services contained in the Constitution.

It is submitted that health care services these days are about a lot more than just a private bargain between a purveyor of medical goods or services and a consumer of those goods or services. There is a very real public interest in the manner in which health care services are delivered, in the nature of those services and in the extent to which they are available to those who cannot afford to pay for them. Notions of social responsibility are central to the philosophies of many large corporates including the need to uplift the poor, protect the environment and promote the health of the communities within which they operate. In legal philosophical terms it is no longer 'every man for himself' but the need to balance the interests of the individual (which includes not only men, but also women and children in these enlightened times) against those of society as a whole that is important. It is not so much 'bargains' that should be the concern of contracts between provider and patient in the health care context but quality, safety and efficacy and a fair price to the consumer for something that is starting to be regarded by economists and other disciplines as a public good[9].

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9 Merson M in 'SARS Proved Health is Global Public Good' *YaleGlobal Online* states that globalization facilitated both the spread and the containment of SARS causing coronavirus. He points out that modern travel and labour migration patterns helped spread the disease, and global links amplified its political and economic impact. Simultaneously, modern communication and science alerted the world to the disease and facilitated a strong public health response. SARS thus imparted a fundamental reality: health is a global public good. It demonstrated that domestic and global healthy policy can no longer be divided because local health problems can have global repercussions.
The IHPN in 'Health – a Global Public Good' Bulletin Number 10: January 2002 notes that the World Health Organization is calling for a massive investment by the rich governments of the world into the health of the world's poor. This was the conclusion of a report by the Commission on Macroeconomics and Health launched in London on 20 December 2001. It observes that this argument has strong similarities with calls from the United Nations Development Programme (UNDP) for health to be considered a public good. The Commission itself refers to global public goods and defines them as "goods whose characteristics of publicness (nonrivalry in consumption and nonexcludability of benefits) extend to more than one set of countries or more than one geographic region". The article considers the nature of public goods as follows –
"The concept of dividing goods into 'public' and 'private' goods arises from classical economics and can be dated back to the 18th century. According to this concept, characteristics of public goods include:
- Non-rivalry in consumption which means that one person's use of a good does not prevent another person from using it…This is termed by some as non-divisibility'
- Non-excludability, i.e. use of item is available to all people/groups of people…
- Non-rejectability, individuals are unable to choose to forego consumption…

However this distinction between private and public goods is not always that clear cut. Although some goods might be purely private or purely public, there will be some that are mixed/impure. Goods which are non-rival amongst a certain group of people can be termed 'club goods' and those which are available to all but are rival can be termed 'common pool resources'. These impure goods are more common than the pure type. Consequently the term public good is often used to include both pure and impure public goods…Commonly five sectors of public goods can be identified, namely environment, health, governance, security and knowledge…According to neo-classical economic theory, attempting to provide pure public goods through competitive markets will lead to sub-optimal quality, quantity and price… Two reasons for this can be identified… First, individuals motivated by self-interest only will tend to 'free ride' concerning

Research and development of medicines that is purely profit driven leads to the marginalization of diseases and conditions that, should they break out on a global scale, could seriously impact upon the world economy. The comparatively recent SARS scare is a good example of how a relatively obscure disease can suddenly become of global significance[10]. Taking all this into account it is submitted that one cannot justifiably conclude that health care goods and services are no different to any other goods and services. This in turn carries the implication that contracts in the private health sector should be regulated to reflect these differences as should those who provide health care services and goods within this sector. The South African government has in recent years started to give legislative recognition to these same

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the provision of these goods. Secondly, individuals will tend to make sub-optimal decisions on these issues if those decisions are made in isolation from others. Effective provision of public gods requires co-operation and measures which promote communication and trust." The article concludes that- "It seems uncontroversial that certain aspects of health can be considered a global public good, particularly the control of infectious diseases which can spread across national boundaries. However, in an increasingly globalised world it can be argued that more and more the cause and effects of disease are transnational. Finally it can be argued that all of health should be considered a global public good because it is a key component of another global public good, poverty reduction, and because the global community has determined that it should be so considered." http://www.iphm.org/bulletin10.htm

10 Pablos Mendez A, of the Rockefeller Foundation Centre for the Management of Intellectual Property in Health Research and Development has pointed out that globally from 1975 to 1997 although 1233 new chemical entities were registered only 11 were products for tropical diseases of poverty and half of these were for veterinary purposes.
http://www.mrc.ac.za/conference/IP/pablosmendez.pdf
Vandersmissen W of Government & Public Affairs, SmithKline Beecham Biologicals stated some of the dynamics of the problem in a presentation during Session 46, Global Public Goods in Health: Developing AIDS, Malaria & Other Priority Vaccines Washington, February 28 - March 1, 2000 World Bank Human Development Week that: "The fiduciary responsibility towards shareholders must guide all investment decisions in a vaccine company. This includes finding ways to reconcile the contradictory requirements posed by the development of vaccines that are public goods with high social value but little or insufficient return on investment. Good corporate citizenship requires seeking solutions that do not deny the benefits of a company's know-how and expertise to the less well-to-do people and countries of the world. These solutions require public-private partnerships that help the development, distribution and use of such vaccines. The introduction and expanding use of a new vaccine will follow a typical pattern: during a period of early demand, the vaccine will be launched in the private market of industrialised countries; later, it will be integrated into public health policy of industrialised markets. Finally, the vaccine gets to be generally used, with massive purchases in the public markets of developing countries. During this evolution, that may take 15-20 years, the average selling price and profit margin per dose decreases. This has lead to the expectation that all vaccines will end up becoming very cheap, and that efforts must be deployed to hasten the evolution. However, this reduces the timespan over which a manufacturer can recoup his investment. Under this traditional market evolution pattern, vaccines with little or no private market will not be attractive. The advantages and disadvantages of the various market segments through which a vaccine moves can be easily summarized: the more a market segment is characterised by reasonable margins and by a high degree of predictability (or a predictability that can be influenced by a dedicated marketing and distribution effort), the more attractive that market segment is. Financial analysis will show the net present value of expected gross profit in private and public markets of industrialized countries to be a manifold of the modest contribution that can be expected from even very large volumes of sales at low prices in developing nations. Support from public sources is required to power the development of public good vaccines for which the market is deemed unattractive. The discovery effort is generally funded by public monies, and has yielded over the past decade a very high number of potential vaccine candidates through existing and well-performing academic research. Preclinical and clinical development needed for the eventual registration must however associate industry's expertise and contribution with public support: the so-called "push" mechanisms that are available from public sources. Simultaneously, steps must be taken to ensure an industrial production process is developed and a production unit of appropriate capacity is constructed. Finally the vaccine will not reach its end-users if there is no financial support form rich countries to help poor nations to purchase the vaccine. The latter "pull" mechanisms would allow UN procurement agencies such as UNICEF to continue playing their role as buyers and distributors of the vaccine. Push mechanisms are therefore a way to solve the dilemma posed by public good vaccines that do not have attractive market terms. They are also a desirable mechanism to share the risks inherent to the development of a vaccine for which the scientific odds are, in the present state of our knowledge, highly uncertain. A particular case where push mechanisms would be desirable is the need for the establishment of a vaccine plant of adequate capacity. As the output of a plant of e.g. a malaria vaccine will be directed almost exclusively to the less attractive markets, the financing of such a capital investment would obviously benefit from specific push mechanisms. It must be noted that the decision to invest for any given global capacity, must be taken several years before the vaccine eventually is registered."

perspectives on health service delivery. The amendment[11] to the Medicines and Related Substances Act[12], made express provision in section 22G for a transparent system for the pricing of medicines including a single exit price which is the only price at which medicines may be sold to persons other than the state. The intention behind the section is evidenced by other sections of the Act as amended notably sections 18B and section 18A. The regulations envisaged by this section have been written relatively recently and it is clear that the idea of trading in medicines is no longer supported by government policy or legislation. Those who supply medicines are entitled to a professional fee for services rather than a mark-up on the cost price of the medicine. In legal terms this means that the provider-patient contract where the former is a dispensing doctor or retail pharmacist will be a mixed one – for goods and services in the majority of cases - in which both elements are clearly visible to the consumer in terms of what he is paying for. Systems of bonusing, rebates and volume or bulk discounts and sampling that are common trade practices in other sectors have been outlawed by the Medicines and Related Substances Act, emphasising the idea that medicines are no ordinary commodity. Over and above this, however, provision is made for the prescription by the Minister of Health of the fees that wholesalers, distributors, retail pharmacists and dispensing doctors may charge with regard to the activities that surround the supply of medicines, once again making the point that health services are also different to services in other sectors.

The National Health Act provides for a system of licensing of all providers of health care services taking into account *inter alia* the need to ensure consistency of health services development in terms of national, provincial and municipal planning; the need to promote an equitable distribution and rationalisation of health services and health care resources, and the need to correct inequities based on racial, gender, economic and geographical factors; the need to promote an appropriate mix of public and private health services; the demographics and epidemiological characteristics of the population to be served; and the need to ensure the availability and appropriate utilisation of human resources and health technology.

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11 Act No 90 of 1997
12 Act No 101 of 1965

It is submitted that it is against these legislative and policy backdrops that one must construe the delivery of health care services within the private sector. Socio-economic rights have been recognized by the constitutional court as being justiciable[13]. The subject matter of these rights in South Africa can never again be seen as mere commodities in trade.

6.2 Case Law

6.2.1 Argus Printing and Publishing Co v Dr Van Niekerk[14]

Facts

The appellant, the Argus company, the owner of a printing establishment in Johannesburg, had in its employment a youth, Richard Eagleson, who was very seriously injured while at work in the appellant's printing room. The father of the youth sued the appellant in his son's name for damages for the bodily injury suffered by him through the negligence of two engine drivers in the company's employ and obtained judgment for £500 on the boy's behalf. Immediately after the accident Dr van Niekerk was called in on the instructions of a director of the company to render medical assistance to the youth. He found him in a very dangerous condition and caused him to be conveyed immediately to the Johannesburg hospital where he was treated by the respondent during December 1894 and January and February 1895. The respondent claimed payment from the company for his services to its young employee on the ground that he had acted on the request of one of the directors. Shortly after the accident, a director had sent one of the workmen to fetch the doctor and that the managing director of the company had given the respondent the assurance that he would place his memorandum of fees before the Board of the company and that he need not worry as far as his fees were concerned as payment would be made after completion of certain negotiations with a view to settlement between the company and the father of the injured youth in which they were then engaged. The father, however, refused to accept the company's proposal and obtained judgment in his

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13 *Soobramoney v Minister Of Health, Kwazulu-Natal* 1998 (1) SA 765 (CC); *Government Of The Republic Of South Africa And Others v Grootboom And Others* 2001 (1) SA 46 (CC); *Minister of Health and Others v Treatment Action Campaign and Others* (No 2) 2002 (5) SA 721 (CC)

14 *Argus* (1895) 2 OR 40

favour against the company. After the judgment, the managing director, Darmer, denied that the company was responsible for the respondent's fees because the company had been discharged by the judgment of the court awarding damages to the father of the boy from all further liability arising out of the accident. The respondent then sued for the recovery of his fees of £52 10s due to him for medical services and the Judicial Commissioner gave judgment in his favour on the ground that Darmer, as the managing director of the company had confirmed the action of the director in calling the doctor out and had undertaken to pay the respondent's fees.

Judgment

Kotzé CJ stated that the question whether the appellant was liable for the respondent's fees depended on the special circumstances of the case. He ruled that the court could not accept the contention that the company was not liable for the respondent's fees because Sheffield, the director on whose instructions that youth had been taken to hospital, must have supposed that the doctor would continue to treat him at the hospital and it could not be argued that the doctor had only been called in to give on the scene medical treatment. The court noted that it is the custom in the hospital for a private doctor to visit the patients who are admitted there and that when a director of a company causes a doctor to be called in to render professional assistance to an employee of the company who has been injured in its service, there are reasonable grounds for the doctor to suppose that the company makes itself responsible for his fees. Admitting that the assurance given by Darmer to the respondent that he would be paid does not either directly or indirectly make the appellant company liable, said the court, its liability can still be deduced from the fact that Darmer agreed to lay the respondent's bill before the Board of the company and also from his letter to Eagleson's father in which he expressed his willingness to pay the expenses caused by Eagleson's illness. The appeal was dismissed.

Discussion

It is interesting to note that in this very old case the court did not once make reference to a contract between the doctor and the company although, technically speaking, it

could be argued that one did arise. There is no mention made as to whether the court in awarding judgement in favour of Eagleson, the injured youth, including in its award the costs of medical expenses incurred as a result of the accident. It may be that it was on this basis that the company adopted the view that it had already paid its debt in respect of the boy's injuries and may even have felt that the doctor should claim his fee from the boy's father. Unfortunately there is no reference to the relevant facts in the judgment and so the foregoing comments are mere speculation. In contractual terms it could be argued that the liability of the company to the doctor existed independently of its liability to the youth for his injuries and that the judgment of the court in favour of Eagleson in the allied action did not exterminate the liability of the company to the doctor on the basis of their contractual arrangements because even if the company did consider that its debt to the boy had been discharged by the other judgment the fact remained that it was still indebted to the doctor for his fees. It would not be fair or reasonable to expect the doctor to require payment of his fees from the boy or his father, in view of the agreement that had arisen between the doctor and the company, even if it was for the benefit of a third party. Even in the absence of a contract between the doctor and the company, it is submitted that on the basis of the actions of the director and the managing director, it would be estopped from denying liability for the doctor's fees since he was entitled to rely on the representations (or misrepresentations) that were made to him by two senior officials in charge of the company's affairs. The undertaking to lay his bill before the Board of directors could not be seen as diminishing the undertaking that the doctor was given because he was told not to worry about his fees as payment would be made after the settlement had been negotiated with the boy's father.

6.2.2 ***Tulloch v Marsh***[15]

Facts

In this case a dentist supplied and fitted a set of artificial teeth made from his own material for an inclusive charge to the defendant's wife. He sued the defendant for the amount of £10 10s. The defence was that the claim, being for professional services was prescribed by virtue of the Placaat of Charles V. The plaintiff after taking an

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15 *Tulloch* 1910 TPD 453

impression of the mouth, made a vulcanite plate to which he fixed suitable teeth purchased by him. The material costs were in all about £1.

Judgment

Innes CJ stated that the question to be decided is whether an account rendered by a dental surgeon in respect of a plate and artificial teeth supplied in 1905 is prescribed by the Placaat of Charles V. The Placaat was repealed by an Act of 1908 but its provisions were still in force in cases where prescription had run before the passing of the Act. In this case it had run before that date. According to the Placaat, the fees of advocates, doctors and 'other workers' prescribed after two years and the magistrate used the case of *Lowle v Johnstone*[16] to support the interpretation that 'other workers' meant those who did similar work to the professional and clerical work done by the persons enumerated in the Placaat. The question was thus whether the contract was one for sale of the finished teeth, manufactured by the skill of the dentist employed, or whether it was a hiring by the client of the skilled labour of the dentist. Innes CJ stated that contracts of sale and of letting and hiring resemble one another and referred to a rule in the Digest (19,12,3 and 18,1,20) and also a passage from the *Institutes* referred to in argument and stated that it was a very simple one. When the client supplies the material and the other party the work then it is letting and hiring. When the workman produces an article manufactured by himself out of his own material which he supplies to the customer then the contract is one not of letting and hiring but of sale. He observed that this rule was approved by Pothier and was simple and easy of application. It was founded, said Innes CJ, upon a real distinction of legal principle and he could not see that there was any weight of Roman-Dutch authority against it. He said he did not think that the passage quoted from Grotius rightly interpreted, is the other way and the only writer that adopts a contrary view is Huber. Innes CJ stated that it did not differ from the rule followed by the English courts in *Lee v Griffin*[17]. There the principle was stated in this way: Does the contract result in the sale of a chattel? If so, it is a contract of purchase and sale. It can only so result, said Innes CJ, when the material is supplied by the person who does the work. That is exactly the same principle as is laid down in the *Digest*. That principle, he said, was

16 *Lowle* [1907] TS 1069
17 *Lee* 30 L.J. Q.B. p254

far more satisfactory than the rule that the contract should be included in the one category or the other, according as the value of the labour, or the material, happens to preponderate. Because that rule is not founded upon any principle at all whereas the other is. The passage in the *Digest*, 19.2.22, deals with the building of a house. That, said Innes CJ appeared to be a contract standing very much by itself. It could be a contract of sale, because the contractor does not sell the bricks and mortar and stone which he puts into the house; nor does he sell the completed house, because it never belonged to him. It approximates to a contract of letting and hiring, and was therefore, held Innes CJ, rightly included by the Digest in that class of contracts. He stated that it does not, however, affect the general rule laid down in the other passages of the Digest to which he referred. Innes CJ did not agree that a distinction should be drawn between cases where articles are bought ready made and prepared for the general market and those where they are ordered specially by the customer at his own special direction and according to his own special measurement or choice. He said he could see no distinction in principle in that rule either. Innes CJ conceded that there may be difficult cases on the borderline – as for instance where both the customer and the person who does the work supply a portion of the material. It would be difficult, he said, to determine in such a case within which category the contract fell. That would be a case where one would have to take into account the difference between the value of the material and the value of the work. Innes CJ decided that the contract in the present case was one of sale and that although the dentist applied a great deal of skill in the making of the false teeth, he supplied the material, he made the plate and it was bought by the client. The appeal therefore succeeded.

In his judgment Solomon J concurred that the appeal should be allowed. He stated that contracts of sale and *locatio conducti* are very near akin to one another and that it is sometimes difficult to distinguish whether a contract is one of sale or of letting and hiring. Each case, he said, must depend on its own circumstances. He agreed that the principle in the English case of *Lee v Griffin*[18] was substantially the same as that laid down by the Digest. Where the material is supplied by the person making the finished article by his skill, and he supplies it when it is finished, then the contract is one of sale. When the material is supplied by the person for whom the article is made and the

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18 *Lee* fn 17 *supra*

other party to the contract employs his skill upon the material of another, then the contract is one of letting and hiring.

Discussion

The decision in *Tulloch v Marsh* was subsequently applied in *SA Wood Turning Mills (Pty) Ltd v Price Bros (Pty) Ltd*[19]; *S* v *Progress Dental Laboratory (Pty) Ltd And Another*[20]; *Carpet Contracts (Pty) Ltd v Grobler*[21]; *Forsyth And Others v Josi*[22] and in *Polpark Dispensary (Pty) Ltd v SA Pharmacy Board*[23].

Strauss[24] comments with regard to *Tulloch* that legally speaking the contract between a doctor and a patient would be for the letting and hiring of work (*locatio conductio operis*) but that the court decided that with regard to dental services in this case that the transaction legally amounts to a sale and not one of letting and hiring of services. He notes that one of the interesting implications of this ruling is that the equitable relief of the dentist claiming a reduced amount for the work done by him, irrespective of its shortcomings, does not apply in respect of dentures and points out that the patient who complains of a patently defective denture would be entitled to reject it, cancel the contract with the dentist and claim damages for breach. In the case of latent defect, says Strauss, the patient would be able either to claim recission of the contract or retain the denture and claim a reduction on its price. He states that these legal remedies are available to the patient even if the dentist did not expressly guarantee satisfaction. Contracts for the sale of goods therefore have somewhat different implications to contracts for the letting and hiring of services in the health care context. Whilst generally speaking contracts for the letting and hiring of services in relation to health care come with no guarantee of a cure or undertaking as to the end result of those services, contracts for goods must meet the reasonable expectations of the purchaser and the seller can be held liable for latent defects. It has previously been

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19 *SA Wood Turning* 1962 (4) SA 263 (T)
20 *Progress Dental Laboratory* 1965 (3) SA 192 (T)
21 *Carpet Contracts* 1975 (2) SA 436 (T)
22 *Forsyth* 1982 (2) SA 164 (N)
23 *Polpark* 1978 (2) SA 816 (A).
24 Strauss *Doctor Patient and The Law: A Selection of Practical Issues* at p 69

observed that where the seller professes expertise in the good sold he can also be held liable for consequential damages[25].

In modern dental practice it is rarely the dentist who makes up the dentures but more commonly the dental technician. The dental technician currently has no direct contact with members of the public as customers. His customers are the dentists who extract the teeth of the patient, take the moulds for the dentures and subsequently fit them into the patient's mouth once the dental technician has constructed them. The dentist in effect therefor sub-contracts the work of constructing the dentures to the dental technician. Strauss comments that the *Tulloch* decision was interpreted by dentists as meaning that a fee cannot be recovered unless the patient is satisfied with the denture. He makes the point, however, that whether or not the denture is suitable must be objectively ascertained and the patient's view on the subject is but one factor. Where a dentist supplies a denture to a patient that has been constructed by a dental technician it is submitted that the contract is a mixed one for both the letting and hiring of services and the sale of the denture. The dentist himself only provides the services while the dental technician supplies the dentures through the dentist. He offers the view that where a crown or a bridge is supplied to a patient the contract is unlikely to be one of sale but is rather one of the letting and hiring of services on the basis that the crown or bridge is fixed into the patient's mouth. It is submitted, however, that it might be more realistic to regard such a contract as a mixed one since the ownership of the crown or bridge, which is a physical object, hopefully passes to the patient upon payment of the dentists fee.

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25 See *Kroonstad Westelike Boere-Koöperatiewe Vereniging Bpk v Botha and Another* 1964 (3) SA 561 (A); *Jaffe & Co (Pty) Ltd v Bocchi and Another* 1961 (4) SA 358 (T); *Holmdene Brickworks (Pty) Ltd v Roberts Construction Co Ltd* 1977 (3) SA 670 (A). In the latter case it was held that broadly speaking, a defect may be described as an abnormal quality or attribute which destroys or substantially impairs the utility or effectiveness of the res vendita for the purpose for which it has been sold or for which it is commonly used. Such a defect is latent when it is one which is not visible or discoverable upon an inspection of the *res vendita*. See also *Langeberg Voedsel Bpk v Sarculum Bpk* 1996 (2) SA 565 (A); *Sentrachem Ltd v Prinsloo* 1997 (2) SA 1 (A); *Ciba-Geigy (Pty) Ltd v Lushof Farms (Pty) Ltd en 'n Ander* 2002 (2) SA 447 (SCA) in which it was held that a merchant-dealer who publicly professes to have expert knowledge in respect of the type of product that he sells is liable to the purchaser under the actio empti if the latter should suffer consequential damage as a result of a latent defect in the *res vendita*. A latent defect is defined as an abnormal quality or attribute which destroys or substantially impairs the utility or effectiveness of the res vendita for the purpose for which it has been sold or for which it is commonly used. f a manufacturer produces and markets a product without conclusive prior tests, when the utilisation thereof in the recommended manner is potentially hazardous to the consumer, such negligence on the part of the manufacturer may expose him to delictual liability to the consumer. Where the consumer does not acquire the product directly form the manufacturer, and the manufacturer is thus a third party, such liability amounts to what is sometimes termed 'product liability'. A contractual nexus between the manufacturer and the consumer is not required. Although the historical origin of the manufacturer's liability is an agreement between the manufacturer and the distributor, the liability, which arises from the manufacture and distribution of the product, extends via the other contracting party to any third party who utilises the product in the prescribed manner and suffers damage as a result thereof. It follows as a matter of course that a manufacturer who distributes a product commercially, which, in the course of its intended use, and as the result of a defect, causes damage to the consumer thereof, acts wrongly and thus unlawfully according to the legal convictions of the community.

In *Polpark Dispensary (Pty) Ltd v SA Pharmacy Board*[26] the crisp question was whether the business that the appellant, a body corporate, wanted to conduct on certain premises in Springs was that of "a retail pharmacist" within the meaning of s 22 (1) (e) of the Pharmacy Act[27] ("the Act"). If it was, it could not be carried on, for appellant would then not be entitled to be registered as a pharmacist under the Act and hence could not practise as such. It then followed too that the respondent, the South African Pharmacy Board ("the Board"), would have correctly declined appellant's application for registration under the Act; that the Transvaal Provincial Division rightly dismissed the appellant's appeal to it under section 24 and that appellant's present appeal must be dismissed. The converse would apply if the answer to the above question was in the negative: appellant's present appeal must then succeed and its registration as a pharmacist be ordered.

Trollip JA held that the essence of "retail" in its less wide sense is the selling of commodities in small quantities to the ultimate consumers, whether directly or through agents of either the seller or the consumers, and whether to the public at large or to an exclusive or limited body of consumers. The court stated that a dispensary to a nursing home located inside its administrative section and conducted solely and exclusively for the nursing home and its patients, all medicines to be dispensed and supplied by it on prescriptions for patients in the home and sold and supplied to the nursing home and not to the patients, the nursing home paying the dispensary for them but thereafter receiving its disbursements from the patients is a "retail pharmacist" within the meaning of s 22 (1) (e) of the Pharmacy Act which provides that no corporate body shall be registered as a retail pharmacist unless it "shall have been carrying on business as such immediately prior to the commencement of this Act". It was argued that, according to the above dictionary definitions, the essence of "retail" is trading, i.e. the selling of commodities; that, by merely supplying medicines to order on prescriptions a pharmacist, a professional man, does not sell and thus trade in them; that a "retail pharmacist" therefore can only connote one who, in addition to compounding and/or supplying prescribed medicines, trades by selling the other

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26 *Polpark* fn 23 *supra*

27 Pharmacy Act No 53 of 1974

miscellaneous goods previously mentioned; and that, as appellant will not trade in such goods, it will not be a retail pharmacist. In support of that argument counsel relied on In *re Medicaments*[28], a decision in the English Restrictive Practices Court. There the learned president (Buckley J) said at 1344H:

"The business of retail chemist consists of: (a) dispensing in response to prescriptions from doctors or dentists, (b) the sale of proprietary medicines, and (c) the sale over the counter of a large number of miscellaneous goods, such as cosmetics, photographic material, toiletries and so forth, which have become traditionally connected with the trade of a chemist."

The argument, said Trollip JA is untenable. To start with its major premises are fallacious. Where a pharmacist uses his own chemical substances in compounding a prescribed medicine and supplies the finished product for a price to the consumer, he undoubtedly, according to the law, sells it... That also applies, of course, where he supplies the prescribed medicine from his stock. He thus trades in all such medicines. That he also trades or does not trade in the other miscellaneous goods mentioned above is irrelevant to the question whether or not he is a retail pharmacist in terms of the Act. For the Act is concerned with the pharmacy profession, not with the extra-pharmaceutical or general dealer activities of pharmacists. Hence the question under consideration is to be answered by reference to a pharmacist's activities with medicines and not with the other miscellaneous goods. The fact therefore that appellant will not trade in the other miscellaneous goods is of no significance. The court held that the above-quoted dictum in the Medicaments case did not further counsel's argument at all. It said that the learned president there was not construing the phrase "the business of retail chemist" as a matter of law; he was merely stating the kind of business that retail chemists in fact ordinarily carry on in the United Kingdom, as revealed by the evidence before the Court.

The element of selling to the public mentioned in the definitions of "retail" in the Afrikaans dictionaries, and the aspect of such selling usually occurring from a shop or a place otherwise accessible to the public, as mentioned above in the *HAT* definition of "retail", were also relied on. Counsel argued that the appellant, in selling the prescribed medicines only to the patients in the clinic, would not be trading with the public; and that the appellant's dispensary is not a shop or similar premises, but, on

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28 *Medicaments* (1970) 1 WLR 1339

the contrary, they are private premises and not accessible to the public at all. Counsel also relied on *Turpin v Middlesborough Assessment Committee*[29] and other similar cases that all deal with the expression "a retail shop" in an English rating statute. This argument said the court, is also untenable for these reasons. Selling to the public is not an essential ingredient of a retail trade. In any event, the patients in the clinic, to whom the appellant sells the medicines prescribed for them all come from the public; while in the clinic they can thus be regarded as members of the public, albeit only an exclusive or limited section thereof; so this particular point made by the appellant's counsel, said the court, loses its force. Moreover while retail trade is usually conducted from a shop on a street or in a place open to the public, that too is not essential in respect of a retail pharmacist or pharmacy. According to s 1 of the Act, "pharmacy" means "any place where is performed any act specially pertaining to the profession of a pharmacist". A retail pharmacist can therefore carry on his business at any place or premises and not necessarily in a shop. Turpin's and the other cases referred to *supra* were therefore all inapplicable to the problem in hand. In Turpin's case the question was whether for rating purposes under the English Rating and Valuation (Apportionment) Act[30], certain premises were primarily occupied and used for the purposes of a "retail shop". That expression was defined as including "any premises of a similar character" (i.e. similar to the character of a retail shop) "where retail trade or business... is carried on". The premises in question were held to be "a retail shop", *inter alia*, because "the public can resort (to them) for the purpose of having - particular wants supplied therein". The court noted that on the other hand in *Toogood and Sons Ltd v Green*[31], the premises were held not to be "a retail shop" because the premises were not such that the public could resort to them for that purpose if they wanted to. It observed that in *Dolton Bournes and Dolton Ltd v Osmond*[32] a similar conclusion was reached. But, said the court, in these and other like cases that were quoted, an entirely different statutory provision was being construed and applied. There the inquiry wits into both the character of the premises and the nature of the trade or business conducted on it. It referred especially to *Ritz Cleaners*

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29 *Turpin* 1931 AC 452 at 470 *et seq*
30 1928
31 *Toogood* 1932 AC 663
32 *Dolton Bournes* (1955) 1 WLR 61 (CA)

Ltd v West Middlesex Assessment Committee[33] where this nature of the inquiry was emphasised. The basic consideration was whether or not the premises were those of a shop, which ordinarily means a place to which the public resort for their wants. In the present case the court found that the premises were of no materiality. It was the nature of the business to be conducted in them that was decisive. For these reasons, said the court, those cases were inapplicable and the argument was untenable. It noted that whilst the appellant would also supply the clinic direct with its own medical requirements, referred to above as ward stock, some would be supplied on, and others without prescriptions. The clinic would keep them and would in turn supply them to its patients in terms of s 29 (3) (e) of the Act. The court assumed, without deciding in favour of appellant, that the clinic could not be regarded as the ultimate consumer of these commodities, that this part of appellant's activities would not be negligible and that it would not constitute retail trading. Nevertheless, it said, that did not assist the appellant. It was clear that a substantial, if not the main, part of its activities would be the selling of prescribed medicines to the patients in the clinic. So long as this situation prevailed, said the court, it would be a retail pharmacist. This was the part of its proposed activities that offended against s 22 (1) of the Act and precluded its being registered as a pharmacist. The court found that that flaw in its application for registration was not remedied merely because it would also carry on other activities that were non-retail. The final conclusion therefore was that the appellant would be a retail pharmacist within the meaning of s 22 (1) (e) of the Act, that the Board correctly so decided and correctly refused its application for registration, and that the TPD rightly dismissed its appeal.

The intention of the government as evidence from the provisions of section 22G of the Medicines and Related Substances Act[34] as amended is to change the emphasis within pharmacies and wholesalers from of trade in medicines to professional services in respect of which fees are payable. In such an environment the pharmacist will be in much the same position as the dentist selling dentures constructed by a dental technician and, it is submitted, the contract will be a mixed one for the sale of goods and the letting and hiring of services.

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33 *Ritz Cleaners* (1937) 2 KB 642 at 672 per Greene, LJ •

34 Medicines Act fn 12 *supra*

6.2.3 *Sutherland v White* [35]

Facts

The plaintiff, a dentist, extracted the teeth of the defendant and agreed to supply him with a set of false teeth for an amount found by the magistrate to be £22 10s. A temporary set was supplied at the beginning of August 1909. In September 1910 the plaintiff supplied the defendant with a permanent set. On October 17th 1910, the plaintiff wrote demanding payment. The defendant replied by letter to say: "Then again I only got my teeth on 28th September, which unfortunately are not correct yet. Independent of that I shall carry out my part and will let you have what I can this month..." In February or March 1911 the defendant wrote to the plaintiff's assistance, Nisbet, and complained of the fit of the lower case of the set supplied by the plaintiff. Nisbet took a fresh cast and remade the lower case. Two or three weeks later the defendant returned and Nisbet adjusted the 'bite' of the back teeth and lower jaw. In June 1911 the upper case was remodelled by Nisbet who stated that the defendant at the time seemed satisfied. In August 1911 the defendant again told Nisbet that the teeth were not comfortable. During that month an account was sent by the plaintiff to the defendant who wrote on 8th August: 'I am in receipt of your account today. Please send me a correct statement and I shall remit an instalment as per our agreement." The defendant paid £15 on account. The plaintiff sued for the balance which he alleged to be £12 10s. The defendant counterclaimed that, if the plaintiff had failed to supply him with a properly fitting set of false teeth, he should be ordered to repay the defendant the amount already paid by the latter to the plaintiff, the defendant tendering to return the set of false teeth. Judgement was given in the court a quo in favour for the plaintiff because the defendant made no complaint as to the teeth after July 1911 and did not return them or take steps to have them altered by the plaintiff after that date. He was therefore taken to have accepted them in spite of their being unsatisfactory and was therefore liable for an amount of £7 10s.

Judgment

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35 *Sutherland* 1911 EDL 407

Kotzé JP stated that it was necessary to look at the nature of the contract and the conduct of the parties. He observed that it may be quite true on the authority of *Le Roux v Visser*[36] and *Thurston & Co v Judlin & Co*[37] and many other cases decided by the courts that if a person keeps an article after has become aware of a defect or that the quality of the article is not according to sample, or according to contract in some other respect and does not with reasonable promptness return the article, then the inference may fairly be drawn that he has waived whatever objection he could otherwise have raised by way of a legal defence and that he can no longer resist a claim for payment if he is sued for the value of the goods. The circumstances of the present case, were, he said, peculiar and that the nature of the work and of the undertaking which had to be performed by the dentist should be looked at. He noted that it appeared that he himself considered that the teeth not fitting in the first instance it was his duty, as he had undertaken to supply a proper and usable set of teeth, from time to time so to adjust them that they might fit the mouth of the defendant and answer the purpose for which they were originally ordered. This went on up to June and when in August, the account for the teeth was sent in, Sutherland met Nisbet in the street and told him that the teeth were not yet comfortable. The judge president stated that it seemed to him that when a man undertakes to do such a delicate matter as to supply a full set of false teeth, that it is his duty to supply such teeth as to answer the purpose intended. That is his contract which he has to perform. The court found that it could not fairly be said from the evidence that the defendant when he wrote the two letters had in mind the fact that the plaintiff had not performed adequately in terms of the contract. It found that he was in fact saying that he accepted that he owed the money and that the dentist would adjust the teeth so that they fitted properly. The court said, however that it was not clear that the defendant intended to convey by the letters that he intended at all events, whether the teeth fitted or not, to pay the dentist the full amount agreed upon. Consequently it was held that the magistrate erred in ruling that, as the teeth had not been promptly returned the defendant must pay in full. It ruled that the plaintiff could not recover on a contract which he had not properly carried out unless he could show clearly that, notwithstanding that, the defendant undertook to pay for the defective set of teeth. The expert evidence showed that the

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36 *Le Roux* [1911] EDL 381
37 *Thurston* [1908] TH 79

false teeth were in fact worthless to the defendant. Consequently the appeal was allowed with costs and the judgment in the court below altered to one of absolution from the instance.

Discussion

This case, it seems, was also decided largely on the basis of a contract of purchase and sale. However the court also acknowledged the need of the services of the dentist in adjusting the dentures until they fitted properly. The remedy granted was, however, based on the unsuitability of the teeth for their intended purpose and the court effectively permitted the recission of the contract of sale between the patient and the dentist. It is submitted that in reality there is no difference between the nature of the relationship between a dentist and a patient and a doctor and a patient in the sense that the dentist provides mainly services to patients in the form of cleaning, filling and repairing teeth, not to mention the infamous root canal treatment and the treatment of abscesses and similar infections within the mouth and gums. It sometimes happens that due to the nature of the treatment, a product or good is also included in the transaction. The cases involving the sale of dentures clearly do not mean that every contract between a dentist and a patient involves a contract of sale. Dispensing doctors sell medicines to their patients but they also, hopefully, provide diagnostic and other services such as advice to the patient on his or her health condition, the taking of blood pressure and pulse rates etc which means that the contract is a mixed one for goods and services. In situations where a medicine is not suitable for the purpose for which it was sold, the patient should similarly be able to return it to the doctor (provided of course that it has not been opened or substantially consumed) in much the same way as the patient of a dentist can return a set of dentures. Unfortunately in the case of medicines the proof of the pudding is often in the eating and it is only once the medicine has been partially or completely consumed that it becomes apparent that it is not effective or suitable for its intended purpose. However, it is submitted that where a doctor sells a patient a medicine that has expired for example and the patient happens to notice the expiry date on the container prior to using it, he or she is perfectly entitled to return it to the doctor with a request for one that has not expired or a refund for the fee paid for the medicine.

The court in *Smit v Workmen's Compensation Commissioner*[38] set out the distinction between a *locatio conductio operis* and a *locatio conductio operarum* as follows. Joubert JA noted that in Roman law the letting and hiring of the labour or services of free men (*liberi*) could be regulated by two species of *locatio conductio*, viz *locatio conductio operarum* and *locatio conductio operis* (*faciendi*). Since a slave was a mere thing (*res*) he himself was incapable of letting his labour or services but if his owner did so then such a contract was construed as a letting of the slave as a thing (*res*), i.e. *locatio conductio rei*. He stated that *locatio conductio operis* (*faciendi*), involved the letting and hiring of a particular piece of work or job to be done as a whole (*opus faciendum*). This was a consensual contract whereby the workman as employee or hirer (*conductor* or *redemptor operis*) undertook to perform or execute a particular piece of work or job as a whole (*opus faciendum*) for the employer as lessor (*locator operis*) in consideration for a fixed money payment (*merces*). The workman who undertook to perform or execute the work was deemed to be the hirer of the work (*conductor or redemptor operis*) whereas the employer who undertook to pay the *merces* for the execution of the work was considered to be the lessor of the work (*locator operis*). What the parties to the contract contemplated was not the supply of services or a certain amount of labour but the execution or performance of a certain specified work as a whole. Here the subject-matter of the contract was not the supply of services or labour as such but the product or result of labour. The conductor operis, as it were, hired the execution or performance of the work (opus) from the locator operis. The contract was principally utilized in the following ways, viz:

(i) in the building industry where the conductor operis undertook to erect a house or building with his own materials on a building site provided by the locator operas;

(ii) i the manufacturing industry where the conductor operis undertook to manufacture or construct some object from material supplied to him for the purpose by the *locator operis*, eg the building of a ship; the commissioning of a goldsmith to fashion rings from gold delivered to him for the purpose;

(iii) where articles were handed to craftsmen to work on, or to repair or to clean, eg jewels sent to a jeweller to be set or engraved, clothes handed to a fuller to be cleaned;

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38 *Smit* 1979 (1) SA 51 (A)

(iv) in the transportation of goods or passengers;

(v) in the training of slaves.

In all these instances the conductor operis undertook to produce a certain result on a person or physical thing which was handed to him by the *locator operis*. The *conductor operis* was bound to complete the work properly according to the specifications and terms of the contract. Inasmuch as he undertook to produce the promised result or product he was not bound to obey the orders or instructions of the *locator operis* in regard to the manner of carrying out the work. It was moreover not incumbent on the conductor operis to perform the work himself unless otherwise agreed upon. The nature of the work often necessitated the employment of assistants by him, eg to man a cargo or passenger ship, to erect a building, to construct an irrigation canal. There was in principle nothing to prevent him from subcontracting (subject to contrary agreement) since he remained contractually responsible for the finished product. He was liable for all defects in the work (*opus vitiosum*), whether due to his own lack of skill (*imperitia*) or carelessness (*culpa*), or to that of his assistants. It was often agreed that the work had to be performed to the satisfaction or approval (*adprobatio*) of the *locator operis* or a third party who had to judge the quality of the work according to an objective standard (*arbitrium viri boni*). The *locator operis* had to pay the *merces* agreed upon provided the work was satisfactorily executed. The *merces* could be fixed as a lump sum (*per aversionem*) payable upon completion of the work, or could be calculated according to the measure of work done or by time (*per diem*).

Locatio conductio operarum is known in Dutch as "dienstcontract" or "huur en verhuur van diensten". In Roman-Dutch law it covers all contracts of letting and hiring of personal services in respect of domestic servants (*dienstboden, famuli domestici*), workmen (*werklieden*), labourers (*arbeyders, arbeidsmannen*), apprentices, (*ambagtsjongen*), sailors (*bootgesellen, schipsgesellen, schiplieden, schipliên, matrozen*) and other types of employees. The contract of service was not restricted to unskilled services as in Roman law but extended to include skilled services. It should be noted, however, that liberal services (*operae liberales*) rendered by professional men, such as advocates and doctors, fall outside the ambit of *locatio conductio operarum* owing to historical reasons stemming from Roman law. The legal

relationship between such professional men and their clients is construed and treated as a contract of mandate.

In most cases the contract between a health professional and a patient would be a *locatio conductio operis*. It is unlikely that the relationship between health professional and the patient would ever be a *locatio conductio operarum* which is essentially a contract of employment. It is possible that a nurse might be employed to take care of an elderly person by that person or his or her family in which case the nurse might be seen as an employee of a patient. However in many instances such nurses tend to the employees of agencies that supply nurses to persons requiring their services in which case the contractual relationship of employment would be between the nurse and the agency rather than the nurse and the patient.

6.2.4 Oates v Niland [39]

Facts

The plaintiff was a dentist who lived at Somerset East but who made periodic visits to Adelaide in which district the defendant lived. In June 1911 the defendant consulted the plaintiff who made for him a plate containing a certain number of teeth. The defendant was informed that there was generally some difficulty in getting accustomed to the plates and that he must persevere in wearing his. From this time until August 1912 the plaintiff heard nothing further until apparently by accident, the parties met in the town of Adelaide. Between June 1911 and August 1912 the defendant had had a tooth extracted and this had been followed by shrinkage of the gum. During that period of over a year no complaint whatever had been received that the teeth were not fitting and no notice of any dissatisfaction with the plate was given to the plaintiff. The defendant knew where the plaintiff was living yet sent no letter to him. Even in August 1912, he did not repudiate the contract and the teeth showed signed of having been considerably used. He further acquiesced in the plaintiff's suggestions that another tooth should be added to the plate to fill the vacancy caused by the extraction of the tooth referred to.

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[39] *Oates* 1914 CPD 976

Judgment

Under all these circumstances said Juta JP, it would be going very far to say that the defendant had not accepted the teeth. The additional tooth was subsequently added to the plate which was then sent to the defendant and another year passed with not a word communicated by the defendant to the plaintiff to the effect that the plate did not fit. The court said that he could not wait until 1914 when he was sued for payment to complain that he never accepted the plate and that it did not fit. The appeal was allowed with costs and the judgment of the court below altered to one of judgment for the plaintiff with costs.

Kotzé J agreed with the judgment of Juta JP saying that it was the duty of the defendant to notify the plaintiff that the teeth were not suitable and did not fit. Instead he says that he waited for the plaintiff to visit Adelaide. He said it was too late to say that the teeth were unsuitable and distinguished the present case from that of *Sutherland v White* stating that the circumstances in that case were very different to those of the present case.

Discussion

In this case the contract was also essentially one of sale. The patient was, however, using the teeth and made no effort to pay the dentist despite the fact that they were clearly serviceable. If the patient accepts the goods and uses them, it does not lie within his mouth to say that he should not be obliged to pay for them. This case is clearly different from that of *Sutherland v White* due to the fact that the teeth in the latter case were unsuitable. Where the product is of such a nature that it is required to be fitted or adjusted to suit the patient, a proper opportunity to do so must be given to the supplier[40].

6.2.5 *Hewatt v Rendel* [41]

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40 *Shiels v Minister of Health* 1974 (3) SA 276 (RA)

41 *Hewatt* 1925 TPD 679

Facts

A surgeon undertook to remove a growth from the patient for the main purpose of obtaining a bacteriological report from the South African Institute of Medical Research. She had been suffering from an affection of the nose and throat and had consulted several specialists. When it became clear that she was not making progress she was referred to the plaintiff for an operation to remove a specimen from her nose for the purpose of obtaining the report. The operation was done at the Kensington Sanatorium and during the procedure, some of the growth was removed and placed in a bottle which was in turn handed to the theatre sister in attendance. She was instructed to send it immediately to the Institute for testing. When the operation had been completed the plaintiff asked the sister if the specimen had been sent away and she confirmed that it had. That was the last that was seen of the bottle containing the specimen. It never reached the Institute. At the same time Dr Hewat had taken a slide for private examination at his rooms and upon which he based his opinion at the trial as to the plaintiff's condition. After waiting for several days for the report to arrive from the Institute, the defendant's husband was eventually informed that the specimen had been lost. The defendant stated that on hearing of the loss, her condition became worse. She was very ill from the shock of hearing that the specimen was lost and could not sleep. A further operation was undertaken to remove yet another specimen and this was sent to the Institute for examination. The reports were duly obtained. The second operation would not have been necessary if the specimen taken at the first had not been lost.

Judgment

De Waal J observed that the question to be determined was whether the loss of the specimen taken at the first operation was attributable to the plaintiff and whether it is such proof of negligence that justifies a verdict for the defendant on the claim in reconvention. On the one hand the plaintiff contended that he had complied with the terms of the agreement as soon as he had removed the specimen, placed it in the bottle and handed it over to the theatre sister with instructions. He argued that the practice of doing so was reasonable and universally adopted by the profession and that all that was required of him, after having in attendance a duly qualified theatre sister, was to

comply with the procedure not unreasonable in itself and usually adopted at the sanatorium where the operation was performed, which was that the operating surgeon hands the specimen in a bottle to the theatre sister, that she in turn hands it to the nurse in attendance who gives it to the porter for transmission to the Institute by a carrier. On the other hand, observed the judge, it was contended for the defendant that the contract which the doctor had undertaken was specifically for the purpose of ensuring that the specimen reached the Institute and not merely for the purpose or removing it and that the sanatorium through its nurses and porter, never became her agent for that purpose. It was argued that they were intermediaries or agents employed by the plaintiff and that the plaintiff was responsible in law for any loss or damage cause through their negligence. The court stated that if there was an absolute contract undertaken by the plaintiff to transmit or deliver, and if in law the sanatorium became his agent for that delivery, it would seem that his reliance on the practice universally obtaining at the sanatorium, and the fact that the practice was reasonable, was no defence to a counterclaim. The court found that there was no evidence that the practice was universal. A witness from the Institute testified that it did business with doctors only and that a specimen from a layperson would not be accepted. When a specimen was received from a nursing institution the doctor's name had to accompany it and the report was directed to the doctor. As far as the Institute was concerned it was the doctor who sent the specimen. Doctors also daily handed the witness specimens by hand and the Institute also received specimens by post. De Waal J stated that it was not in his opinion the usual concern of either the sanatorium or its theatre sister to see to the despatch of specimens to the Institute.

The court observed that reliance was placed on *Perionowsky v Freeman*[42]. In that case a patient was scalded after having been placed in a bath heated to an excessively high temperature and by being kept therein for an improper length of time. The defendant who had given the instructions to the nurses to give the patient a hot bath pleaded the negligence of the nurses over whom they had no control and it was moreover the usual practice to leave the baths to the nurses. In charging the jury Cockburn CJ said "The defendants cannot be held liable for the negligence of the nurses unless they were near enough to be aware of it and to prevent it". He also relied on *Van Wyk v*

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42 *Perionowsky* (4 F & F 977)

Lewis[43]. In that case the plaintiff sought to claim damages on the following grounds: the defendant, a surgeon, performed a difficult abdominal operation on the defendant. The operation took place at the hospital at night, defendant being duly assisted by a qualified theatre sister. At the conclusion of the operation one of the swabs used by the defendant was overlooked and remained in the patient's body for a period of twelve months. It appeared that at the conclusion of the operation the defendant on being satisfied upon the nurse's assurance that she had duly accounted for all the swabs used, proceeded to stitch up the patient. It also appeared that the system adopted at the hospital at the operation for checking and counting the swabs used was one usually adopted and reasonable. It was held that the surgeon was not liable even if it could be proved, a point not decided, that the sister had been guilty of negligence.

But, said De Waal J, to his mind the principles underlying the decisions in those cases did not apply in the present case for these reasons: Where a difficult operation has to be performed, a patient who employs a surgeon to perform the operation must be deemed to have consented to the employment of the services of a theatre sister as it is manifestly impossible for a surgeon, concerned as he is mainly with the success of his operation and the safety of his patient, to attend to the many details, some of them merely mechanical, which are ordinarily relegated to the sister. Supposing therefore, Dr Heat had, after removing the specimen from the respondent's nose, handed it to the theatre sister and she had negligently dropped it on the floor so as to render it useless for examination by the Institute, he would not be liable. The negligence would be that of the theatre sister for which the operating surgeon could not be held liable as at that stage, i.e. during the operation, she would not be the agent of the surgeon but rather of the patient, who must be deemed to have consented to her present and employment. If therefore the operation is such as to necessitate the presence of a theatre sister, the surgeon would not be accountable for the negligence during the operation. But where the main object of the operation is to remove a specimen from the body of the patient for subsequent analysis, the theatre sister ceases to be the agent of the patient at the conclusion of the operation in so far as the specimen is concerned. Thereafter it becomes his duty, and his alone, to ensure that the specimen reaches its proper destination. That duty he cannot delegate nor has he discharged it until the specimen

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43 *Van Wyk* 1924 AD 438

has been delivered to the Institute. In any failure in that regard, therefore, he is responsible to the patient. If he, instead of making sure that the specimen reaches the Institute, hands it over to another and through the failure of that other it becomes lost, he is answerable to the patient for that loss. It is he who elects to employ an agent for the purpose of transmitting the specimen to the Institute and not the patient, and for the negligence of his agent he is liable to the patient. The theatre sister, the nurse, the porter or the carrier at the Kensington Sanatorium were none of them at any time the agent of the respondent. On the other hand, the appellant cited them as his agents and relied on them to deliver the specimen at the Institute. It was, however, argued that in adopting this means of delivering the specimen the surgeon was not acting unreasonably and that as a reasonable man, he was entitled to assume that the specimen would reach its destination in due course: But, said De Waal J, it is not a question of reasonableness at all. The appellant contracted with the respondent to remove a specimen from her nose and to deliver it at the Institute and he failed to perform one important obligation imposed upon him by the terms of the contract. Had he, for instance, handed the specimen to his own trusted servant who lost it in transmission, he would be allowed legally to plead the reasonableness of this act in employing that servant as a defence to an action by the respondent based on breach of contract. Consequently, said De Waal J, he had come to the conclusion that the appellant was liable to the respondent in damages for the loss of the specimen and that the appeal must be dismissed with costs. Tindall J gave a concurring judgment.

Discussion

This case is a useful illustration of the difference between the law of contract and the law of delict. Failure to perform a legal duty imposed by the law of delict can be defended on the grounds that the tortfeasor was reasonable in his or her actions. Failure to perform a contractual duty cannot since the parties had undertaken the contract with a view to achieving a specific result and the failure of one of the parties to perform a particular act which was a *sine qua non* for that result would constitute breach of the contract. It is quite common these days for the private hospital or other institution to ensure that tissue samples removed in theatre are sent to pathology laboratories or are collected by pathology laboratories were these are remote from the hospital premises. The position of the doctor in such cases would have to be

ascertained from the circumstances of the agreement with the patient since it is unusual these days for doctors to go driving off to pathology laboratories to deliver their tissue samples for testing. If a doctor specifically undertook to remove tissue for the purpose of a biopsy and it was not explained to the patient that the division of work between the doctor and the hospital meant that the latter would be responsible for ensuring that the specimen reached its destination then it is quite likely that the doctor could still be held responsible by the patient for breach of contract in the event of the failure of the specimen to reach its intended destination. Where the object of the treatment was not specifically the removal of a specimen for testing and this was rather an incident of a surgical procedure undertaken for other, albeit related purposes, the loss of the specimen may not necessarily be regarded as a breach of contract on the part of the medical practitioner who removed it for testing. It is likely that in practice in the private sector, litigation due to the loss of a specimen would include both the hospital and the medical practitioner as defendants. The division of labour between doctor and hospital may not be clear to the patient and indeed certain functions might even constitute a joint responsibility. The terms of the contract with the doctor and the circumstances of the treatment in each case would be the determinants of whether or not the doctor was in breach. The decision in this case does not contradict that of *Van Wyk v Lewis* since the court in that case came to the conclusion that it was the responsibility of the nursing sister and not that of the surgeon to count the swabs. The court in that case almost stated in so many words that the patient had sued the wrong person but refused to comment further on the actions or omissions of the theatre sister because they were not before the court. In *Van Wyk v Lewis* there was no express or even implied term in the contract that the surgeon was responsible for the removal of the swabs and it was normal practice for the surgeon and the nursing staff employed by the hospital to work as a team. The removal of swabs from the patient's body in the operating theatre was not the focal point of any contract that the patient and the doctor in *Van Wyk v Lewis* may have entered into. In *Hewatt*, on the other hand, the dispatch of the specimen to the testing facility was part of the raison d'être of the contract. The patient would not have agreed to undergo the surgery if she had known that the specimen would not reach its intended destination.

6.2.6 *Recsei's Estate v Meine* [44]

Facts

The plaintiff, a doctor, performed an operation on the father on the defendant, without obtaining what he knew to be the necessary authority of the defendant and in defiance of the express instructions of the defendant that the operation should be performed by two other doctors, Z and P. The defendant's father subsequently died. The defendant was not informed of the time and place of the operation but on visiting the hospital found that his father was in the operating theatre and the plaintiff was dressing in preparation to operate. The defendant asked where Z and P were and the plaintiff told him that they could not be obtained. The defendant told the plaintiff that he should have carried out his instructions. The plaintiff replied that nothing could be done about it and that Dr A was administering the anaesthetic. The defendant was angry and the plaintiff was evasive and embarrassed. In an action against the defendant, as executor of the deceased's estate, for fees in connection with the operation, the magistrate, though he found that the plaintiff knowingly operated upon the deceased against the defendant's necessary and express instructions, found for the plaintiff on the ground of acquiescence, based on the defendant's failure to stop the operation and on the fact that he allowed the plaintiff to attend the patient for six weeks after the operation.

Judgment

The plaintiff argued that he had operated on the deceased with the full consent of the latter and that no further consent or authority from anyone was necessary to entitle him to payment.

Lewis AJ noted that with regard to the question as to whether the deceased had himself consented to and authorised the plaintiff's operating personally upon him, reliance was placed upon two facts – the "form of consent to operation" signed by the deceased and the direct evidence of the plaintiff. The plaintiff attached great

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44 *Recsei's Estate* 1943 EDL 277

importance to the form and contended that the object of obtaining the signature of the patient to this form was not only to cover the doctor performing the operation but to bind the patient to the doctor whose name appears on the case sheet i.e. in this case the plaintiff. The evidence of Drs Ziervogel and Phillips, however, disposed of this contention. Their evidence was to the effect that the signature of the patient on the consent form does not bind the patient to any particular doctor whose name appears on the case sheet and that the primary purpose of obtaining the signature of the patient to such a form is to protect the hospital authorities by procuring in advance the consent of the patient to submit to an operation; the very wording of the form shows that the patient agrees "to leave the nature and extent of the operation to the discretion of the surgeons." Lewis AJ stated that in his reply to the request for particulars the plaintiff had relied on the "form of consent to operation" in so far only as the date thereof enabled him to fix the date when the deceased had given his express consent to the plaintiff operating upon him; that express consent was there stated to be a verbal consent only. It was alleged that the deceased made no stipulation as to who should consent to the operation when it was discussed with him and that when the plaintiff advised him that he would perform the operation the deceased raised no objection. Lewis AJ said that it did not necessarily follow that because the evidence of the plaintiff on this point was uncontradicted, it should necessarily be accepted. There was only the plaintiff's evidence in support of his allegations. The plaintiff's evidence stood alone and though there was no rule of law that a claim against a deceased estate must be corroborated, it is a sound rule of practice that when such a claim depends on the oral and uncorroborated testimony of the claimant is should be very strictly scrutinised[45]. It was not necessary, said Lewis AJ to decide where this evidence should be accepted because even assuming that it was accepted, this did not conclude the case in his favour. Lewis AJ said it was true that ordinarily the consent of an adult in full possession of his mental faculties (as was admitted to be the case of the deceased) would be sufficient authority for the performance of a surgical operation upon him. But there were some very special features of this case which took it out of the ordinary run of cases and a perusal of the evidence of the plaintiff as a whole satisfied the court that on his own admission he was well aware that in order to perfect his mandate to operate upon the deceased, he required not only the consent of the

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45 *Savory v Gibbs* 20 CTR 600; *Fredman v Yates* [1923] WLD 9; *van der Walt v Crookes* [1941] CPD 244

deceased but also the consent and authority of the defendant. The evidence of the defendant was that the deceased was an elderly man of 68 years of age and in bad health. The defendant says he managed his father's affairs generally on account of his father's insufficient knowledge of English and Afrikaans and he said further that he had undertaken financial responsibility for the expenses of his father's illness. The court said that it did not seem unlikely in these circumstances that the defendant should have been consulted in regard to the proposed operation upon the deceased and that the consent and authority of the defendant should have been regarded as being as essential, if not more essential, than that of the deceased himself. There was also very strong evidence on the part of the plaintiff that he too regarded the proposed operation in this light. The plaintiff admitted that he debited his fees to the defendant and that there was no account against the deceased in his books. He also admitted to discussing the treatment of the deceased with the defendant and that the deceased usually consulted with his son before treatment was carried out. Lewis AJ observed that the fact that there was no account in the name of the deceased in the books of the plaintiff coupled with the defendant's statement that he had undertaken financial responsibility for his father's illness afforded some ground for the view that the action should have been brought against the defendant personally and not against the estate of the deceased. He stated that it at all events lent strong support to the case set up by the defendant that he had a very material, as well as a moral, interest in the proposed operation on his father, that his consent to the operation was in the circumstances necessary and that the plaintiff was fully aware and recognised this. Indeed, said Lewis AJ, the case for the defendant on this point was conceded in the most express terms by the plaintiff himself when he said "the instructions for the operation came from the defendant and his father. I would not have operated without their consent."

In the face of these admissions the court found that it was quite impossible to hold otherwise than that the plaintiff was well aware of and fully accepted the fact that before operating personally on the deceased he required the consent and authority, not only of the deceased but of the defendant as well. In giving judgment the magistrate stated that "it seems to me that plaintiff acted precipitately and without due consideration for the patient and his relatives. His haste was not justified. The probability is therefore that he intended to operate himself against the wishes of the defendant." Lewis AJ said that the only criticism of the court of this remark of the

magistrate is that what the magistrate stated to be a probability appeared on the evidence to be a practical certainty. Lewis AJ stated that on the evidence the plaintiff performed the operation on the deceased without having obtained what was to his knowledge the necessary consent and authority of the defendant and in defiance of the express instructions of the defendant that the operation should be performed by Drs Ziervogel and Phillips.

On the question of whether the defendant acquiesced to the operation Lewis AJ noted that Halsbury Laws of England said of acquiescence that: "in its proper legal sense, it implies that a person abstains from interfering while a violation of his legal rights is in progress and that "acquiescence operates by way of estoppel. It is quiescence in such circumstances that assent may reasonably inferred and is an instance of estoppel by words or conduct". Lewis JA stated that bearing this in mind it was difficult to hold that the conduct of the defendant in the circumstances to which the magistrate referred could be called acquiescence even in the popular sense of the word. The defendant was in no position to stop the operation because steps had already been taken and the patient was already under anaesthetic and had undergone a certain amount of risk. Dr Meine said that nothing further could be done about it and he took the view that if there was a possibility of stopping the operation without danger to his father it was up to Dr Meine on his (the defendant's representations, to stop the operation. The defendant said that he did not consent while in the changing room to the plaintiff's performance of the operation. On the contrary he made it clear that he had no authority. Lewis AJ held that if acquiescence operates by way of estoppel it is impossible to see how or what the events which took place at the hospital could or should estop the defendant from resisting the plaintiff's claim on the ground that the plaintiff had no authority to operate on the deceased. He said that the magistrate erred in regarding the fact that the defendant allowed the plaintiff to continue to care for the patient for a period of six wees after the operation and to perform a post-mortem examination on his body as evidence of acquiescence. The defendant gave two reasons for this. The first was that after an operation, post-operative treatment is necessary and he did not think any other doctor would have taken on the post-operative treatment. The second was that once he had operated on the deceased without the patient's consent, his confidence was shaken. He allowed the plaintiff to continue to treat the deceased because he was in a bad way after the operation and he

was afraid that a change of doctors would shock the deceased in his weak condition. The court said this last reason did not appear at all to be an unreasonable one because the plaintiff had been in attendance on the deceased for several months and the reason why he had originally been called in to attend to the deceased was that he was able to converse with him in German. In any event, said the court, the acquiescence had to be proved in relation to the operation and the fact that the defendant acquiesced in the plaintiff continuing with the care of the deceased after the operation was no evidence of acquiescence to the operation itself. Consequently the court held that the plaintiff was not entitled to any fee for the operation which he performed without the necessary authority of the defendant. It also held that he could not successfully claim the fee of the anaesthetist or the consultant employed in connection with the unauthorised operation assuming that the consultation did in fact, take place. The appeal was allowed with costs and the judgment of the magistrate altered to one in favour of the defendant with costs.

Discussion

In this case the contract was not between the patient and the medical practitioner. If it had been then the court should have found that the patient's deceased estate was liable for the costs of the surgery to the patient. It was if anything between the patient's son and the medical practitioner since the former had taken financial responsibility for his father's medical expenses. The case illustrates the importance of the need to distinguish between informed consent to treatment and the acceptance of contractual liability for payment for that treatment. The patient informed consent of the patient in this case to the surgery performed upon him did not save the medical practitioner from the repudiation of his claim in contract for the expenses incurred. In fact the court in this case suggested that it was not the patient's deceased estate that should have been the defendant in this case but the patient's son in his personal capacity since the medical practitioner knew full well that it was in his personal capacity that he was contracting for his father's medical expenses. The contract between the medical practitioner and the patient's son could have been seen as a *stipulatio alteri* but for the fact that it was apparently never the intention of either the patient or his son that the former should become a party to the contract with the medical practitioner. In fact it was the intention of the son that no contract at all between the

plaintiff and himself or the patient should arise in respect of the surgery to be conducted on his father since the son had expressly stated that he wanted two other medical practitioners to carry out the surgery. There was thus no intention on the part of the son ever to contract with Dr Meine for the surgery on his father. Dr Meine's legal counsel no doubt knew this and it was probably one of the reasons why the action was launched against the deceased estate of the patient rather than against the son in his personal capacity. Technically Dr Meine may have had a claim for unjust enrichment against the patient in the absence of a contractual relationship between them but it seems that this was never pleaded and in any event it would probably have been quite difficult to prove enrichment given the fact that the patient appears to have died not long after the operation was performed. The case is interesting because no legal relationship seems to have arisen between the medical practitioner and the patient despite that fact that the former performed surgery upon the latter.

In any event the decision of the court seems to have been a just one since it appears that Dr Meine deliberately and unethically prevailed upon a weak and ailing old man, in the absence of his son's protective presence and in the full knowledge that the son had requested other doctors to perform the operation, to allow him to perform it instead. Ordinarily, in the absence of a duty of support owed by a child to its aged parent[46], there would be no liability on the part of the child for the medical expenses of the parent due to the legal requirements of privity of contract and the fact that one adult person cannot in the absence of a legal duty of support be held liable for the debts of another[47]. However, in this particular case the son had clearly taken it upon himself to contract for his father's medical treatment as evidenced by the fact that invoices had previously been sent to the son in respect of such treatment of the father by Dr Meine.

The Medical Schemes Act[48] defines a dependant as follows:

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46 In *Smith v Mutual & Federal Insurance Co Ltd* 1998 (4) SA 626 (C) the court noted that: "The question whether the parent is so indigent that a child becomes liable to support his parent depends on all the circumstances of each case. Furthermore, the parent must show that he or she is in want of what should, considering his or her station in life, be regarded as necessities. It must also be mentioned that a parent is not entitled to claim support from a child if the parent is able to maintain himself." See also *Oosthuizen v Stanley* 1938 AD 322

47 See for instance *Atlas Organic Fertilizers (Pty) Ltd v Pikkewyn Ghwano (Pty) Ltd and Others* 1981 (2) SA 173 (T); *Manousakis and Another v Renpal Entertainment CC* 1997 (4) SA 552 (C); *Aussenkehr Farms (Pty) Ltd v Trio Transport CC* 2002 (4) SA 483 (SCA)

48 Medical Schemes Act No 131 of 1998

'dependant' means-

(a) the spouse or partner, dependent children or other members of the member's immediate family in respect of whom the member is liable for family care and support; or

(b) any other person who, under the rules of a medical scheme, is recognised as a dependant of a member;

The question as to whether a member of a medical scheme can be held liable for the costs of medical expenses incurred by an adult family member who is a registered dependent of the member in a situation in which the medical expenses in question fall outside the scope of the benefits payable by the scheme is worthy of further examination. Assume that a son has registered his mother, the recipient of a modest pension, as a dependent with the medical scheme of which he is a member. The mother is admitted to hospital for treatment and the medical scheme pays only part of the bill. Can the hospital, in the absence of an express undertaking by the son to stand surety or on some other basis pay his mother's hospital fees, be held liable for the balance of the account? Paragraph (a) of the definition of dependent seems to suggest that in order for a person to be registered as a dependent of a member of a medical scheme there must be some pre-existing legal liability in terms of a duty of support. Where there is a duty of support the argument that the son in the example under discussion is liable for his mother's medical expenses becomes stronger. However, the duty of support, including the legal obligation to pay for medical expenses, lies between mother and son and not necessarily between the son and the hospital. If the son did not consent to his mother's admission to hospital because he knew that the medical scheme would not pay for certain procedures and instead stipulated that she should be admitted to a government hospital were the costs would be fully covered by the medical scheme, it is difficult to see how he could be held liable for the balance of the private hospital account. His mother, as an adult of sound mind and full contractual capacity had the power to enter into a contract with the hospital in her own right. The son would not be a party to that contract and there can thus be no

claim against him by the hospital merely because his mother is registered as his dependant with his medical scheme. The duty of support of a child to a parent is very much dependent both for its nature and content on the circumstances of each case and is generally quite different to the duty of support owed by a parent to a child. Furthermore, paragraph (b) of the definition of a dependant in the Medical Schemes Act tends to suggest that a person can be registered as a dependant of a member in the absence of a legal duty of support owed by the member to that dependant. Thus the registration of a person as a dependant of a member of a medical scheme is not necessarily proof of a legal duty of support owed by the member to the dependant. A hospital or health professional who tries to hold an adult child liable for medical costs incurred by his mentally competent parent would have to show in the circumstances of the particular case that there was a legal duty of support owed to the parent by that child[49]. If there is more than one child, as is often the case, then technically the duty of support may have to be proven against all of the children and not necessarily just the member of the medical scheme who had registered his mother as a dependant since the duty to support a parent cannot rest on the shoulders of only one child and not those of other siblings[50]. There is a reciprocal duty of support between spouses.[51] In certain circumstances there may even be a duty of support owed by a grandchild to a

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49 In *Smith v Mutual & Federal Insurance Co Ltd* 1998 (4) SA 626 (C) Gihwala AJ observed that: "If parents are indigent, their children, even if minors, are liable to support them in whole or in part, according to their ability: see *Oosthuizen v Stanley* 1938 AD 322, in which Tindall JA said at 327 in fine--328: 'The liability of children to support their parents, if these are indigent (inopes), is beyond question; see, Voet 25.3.8; Van Leeuwen Censura Forensis 1.10.4. The fact that a child is a minor does not absolve him from his duty, if he is able to provide or contribute to the required support; see *In re Knoop* 10 SC 198. Support (alimenta) includes not only food and clothing in accordance with the quality and condition of the person to be supported, but also lodging and care in sickness; see Voet 25.3.4; Van Leeuwen *Censura Forensis* 1.10.5; Brunnemann in *Codicum* 5.2.5. Whether a parent is in such a state of comparative indigency or destitution that a court of law can compel a child to supplement 'the parent's income is a question of fact depending on the circumstances of each case'.

50 Voet, 25.3.11 states: "But in a crowd of a number of persons under obligation for maintenance who ought to be forced to provide it? Are grandsons to be forced to maintain a grandfather if the intermediate father can maintain him, or some wealthy son besides is still in existence?... Can the whole burden of maintenance be imposed upon a single one of a number of children or brothers? It appears that these questions and many others of the same kind cannot so much be settled by definite rules as that they ought rather to be determined in accord with the manifold variety of circumstances, and so ought to be entrusted with the discretion of a cautious and fair minded judge. Those who have avowedly written about maintenance should be consulted on these questions." (Quoted in *Barnes v Union And South West Africa Insurance Co Ltd* 1977 (3) SA 502 (E))

51 Preiss J observed in *Fourie v Santam Insurance Ltd* 1996 (1) SA 63 (T): "The authorities in our law, stemming from Voet 25.3.6 and 8 and numerous decisions confirming these duties, are conveniently collected in *Jodaiken v Jodaiken* 1978 (1) SA 784 (W) by Joubert J at 788H-789B. As to the former, the learned Judge states: 'One of the legal consequences of marriage, whether in or out of community of property, is that the spouses owe each other a reciprocal duty of maintenance according to their means.'...'Another legal consequence of marriage, whether in or out of community of property, and whether *stante matrimonio* or after dissolution by divorce, is that the duty of maintaining their minor children is common to the parents and must be borne by them according to their means.'
The two duties are consistent with one another. They do not conflict, even potentially. This means, in my view, that they exist alongside each other and must be accorded equal status. I shall have occasion at a later stage in this judgment to refer to decided cases in which this co-existence is affirmed. I have found no authority (and none has been cited to me) which suggests that one or the other is to predominate." See also *Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others* 2000 (1) SA 997 (C) and *Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others* 2000 (3) SA 936 (CC)

grandparent.[52] If a private hospital or a medical practitioner contracts with a person without seeking surety from the member of the scheme who has registered that person as his or her dependant in terms of the Medical Schemes Act then it takes the risk of the patient's inability to pay any amounts for which the scheme is not liable. There can be no presumption of a duty of support owed to a parent by a child simply because the latter has registered the former as a dependant.

6.2.7 Friedman v Glicksman[53]

Facts

The allegations made by the plaintiff were:

1. That when pregnant, she consulted the defendant, a specialist gynaecologist, to advise her apropos of the risk that she might have been pregnant with a potentially abnormal and/or disabled infant.

2. It was understood between the plaintiff and the defendant that the plaintiff wished to terminate her pregnancy if there was any risk greater than the normal risks of the infant being born in an abnormal and/or disabled condition.

3. An agreement was concluded in terms of which the defendant would provide such advice in order that the plaintiff might make an informed decision on her

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52 In *Barnes v Union and South West Africa Insurance Co Ltd* 1977 (3) SA 502 (E) Solomon AJ stated: "That our law recognises reciprocal duties of support between grandparents and grandchildren is clear. *Ford v Allen and Others*, 1925 T.P.D. 5 at p. 7. In that case Curlewis, J.P., said: "Our law is clear with regard to the obligations of parents to support their children, and the reciprocal obligation of children to support their parents, and this mutual obligation extends to grandparents and grandchildren both on the mother's and father's side; the obligation and measure of support depends on the necessity for such support, and the ability to render such support and maintenance when required. This is based on the Civil Law as laid down in Digest, 25.3.5." There is apparently, however, a hierarchy in terms of which family members related to one another in various degrees of consanguinity can be held liable to support one another. Solomon AJ observed: "It seems clear that there is an order of priority under the common law. See Voet, 25.3.7, Gane's trans., vol. IV, p. 363: 'If father and mother are lacking or are needy the burden of maintaining grandchildren and other further descendants has been laid by the civil law on the paternal and maternal grandfather and the rest of the ascendants.' It must be pointed out that Voet suggests that there is a reservation that much is left to the discretion of the Judge, but I do not read this as meaning a discretion to avoid the order of priority mentioned." The court noted that in *Oosthuizen v Stanley*, 1938 AD 322 at p. 331, Tindall, JA, said: 'The weight of Roman-Dutch authority is in favour of the view that an indigent brother or sister is entitled to claim support from a brother if the parents are unable to provide it.'
In *Miller v Miller*, 1940 CPD 466 at p 469, Jones, J, said: "In my view the duty to support which falls upon parents, grandparents, children and brothers and sisters only becomes operative so as to give rise to a claim at law when it is proved that the husband is dead or unable to afford support. Primarily the duty falls upon the husband, and it is only when he is dead or unable to provide support that a right to claim support from a parent or child or brother or sister arises. The whole trend of the treatment of the matter by Voet and Huber indicates that a legal right to claim support from a grandparent or brother or sister does not exist unless the parents fail."

53 *Friedman v Glicksman* 1996 (1) SA 1134 (W); *Manousaki's and Another v Renpal Entertainment CC* 1997 (4) SA 552 (C)

own behalf and on behalf of Alexandra whether to terminate the pregnancy or not.

4. In the alternative the defendant, by virtue of his professional status, was under a duty to provide the advice to the plaintiff both in her personal capacity and on behalf of Alexandra for the purpose set out in 3 above. In this regard he had to act with the skill, knowledge and diligence normally exercised by other members of his profession.

5. The defendant, having carried out certain tests, advised the plaintiff that there was no greater risk than the normal risk of having an abnormal and/or disabled child and that it was quite safe for her to proceed to full term to give birth.

6. The defendant's advice was erroneous and Alexandra was born disabled on 5 March 1991.

7. The defendant in giving his advice had acted negligently in a number of respects. Had he not acted in this negligent manner he would have concluded that there was a greater than normal risk of the child being born disabled and would have advised the plaintiff of this fact.

8. Had she received the correct advice the plaintiff would have terminated her pregnancy forthwith.

9. The defendant's negligence was a breach of his duty of care as well as a breach of the agreement concluded.

Based on these facts plaintiff brought two claims:

(a) A claim in her personal capacity for the expenses of maintaining and rearing Alexandra as well as all future medical and hospital treatment and other special expenses.

(b) A claim in her representative capacity on behalf of Alexandra for general damages as well as a claim for future loss of earnings.

The defendant excepted to the claims which were made against him by the plaintiff in her personal capacity and in her capacity as mother and natural guardian of her minor child, Alexandra. He contended that the allegations made by the plaintiff did not disclose a cause of action cognisable in South African law.

The defendant excepted to the claim on the following independent grounds:

1. In so far as the plaintiff's claim was based on a breach of contract, Alexandra was not a party to such contract and cannot be affected by any such breach.

2. The defendant did not owe Alexandra a duty of care which would lead to the termination of her existence.

3. The defendant did not in law act wrongfully against Alexandra.

4. There was no legal basis in South African law for the damages claimed on behalf of Alexandra. A Court is not able to evaluate damages by comparing the value of non-existence and the value of existence in a disabled state.

5. The action was *contra bonos mores* and against public policy.

Judgment

Goldblatt J referred to the numerous legal articles on the subject that had been made available to him by counsel and observed that originating in America and used by most writers and jurists the terminology set out hereunder is useful shorthand for the issues raised. He stated that the phrases however do contain certain emotional and apparent value judgments which can detract from a proper judicial approach to the issues raised.

'Wrongful pregnancy' refers to those cases where the parents of a healthy child bring a claim on their own behalf for damages they themselves have suffered as a result of giving birth to an unwanted child.

'Wrongful birth' are those claims brought by parents who claim they would have avoided conception or terminated the pregnancy had they been properly advised of the risk of birth defects to the potential child.

'Wrongful life' actions are those brought by the child on the basis that the doctor's negligence - his failure to adequately inform the parents of the risk - has caused the birth of the disabled child. The child argues that, but for the inadequate advice, it would not have been born to experience the pain and suffering attributable to the disability.

Thus, said Goldblatt J, different considerations apply to the claims instituted by the plaintiff in that the one claim is a 'wrongful birth' claim and the other a 'wrongful life' claim. The defendant argued that it would be against public policy to enforce the contract entered into between the plaintiff and the defendant because it would encourage abortion and thus be inimical to the right to life enshrined in section 9 of the Constitution of the Republic of South Africa Act[54] as well as to the generally recognised sanctity accorded by society to life and the process by which it is brought about.

Goldblatt J stated that in his view there was no substance in this submission, which flew directly in the face of the Abortion and Sterilisation Act[55]. In terms of s 3(c) an abortion may be procured 'where there exists a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that he will be irreparably seriously handicapped'. Thus, he said, the Legislature has recognised, as do most reasonable people, that cases exist where it is in the interests of the parents, family and possibly society that it is better not to allow a foetus to develop into a seriously defective person causing serious financial and emotional problems to those who are

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54 Interim Constitution (Act No 200 of 1993)
55 Act No 2 of 1975

responsible for such person's maintenance and well being. However, said Goldblatt J, it must be stressed that the election to proceed with or terminate the pregnancy in these circumstances rests solely with the mother, who bears the moral and emotional burden of making such election.

Referring to the decision of the Appellate Division in *Administrator, Natal v Edouard*[56], in upholding a 'wrongful pregnancy' claim and its finding that such claim was not contrary to public policy, Goldblatt J noted that in his view the contract entered into between the plaintiff and the defendant was sensible, moral and in accordance with modern medical practice. The plaintiff was seeking to enforce a right, which she had, to terminate her pregnancy if there was a serious risk that her child might be seriously disabled. Goldblatt J observed that the defendant submitted, *inter alia*, that the plaintiff had no cause of action in that Alexandra's condition was not caused by any act or omission on his part but was a congenital defect arising at the time of conception. He stated that this submission misconstrues the nature of a 'wrongful birth' claim. The claim is based upon the fact that, but for the defendant's negligent advice, the plaintiff would have had her pregnancy terminated. Thus, said Goldblatt J, the defendant was responsible and caused the child, with her disabilities, to be born. He stated that the plaintiff's contention was analogous to a would-be defence in a 'wrongful pregnancy' case that the doctor did not inseminate the patient, ie did not cause the pregnancy. In these cases the defendants were employed to sterilise the patient and thereby prevent the birth of a child. The negligent failure to implement medical procedures properly was causative of the birth of the child - the very event that the defendants were called upon to prevent.

Goldblatt J held that in the present case the defendant was employed to prevent - by way of giving proper medical advice - the birth of a disabled child. Because of his negligence that event had taken place, causing the plaintiff to incur considerable expenses which she would not otherwise have had to incur. He quoted the words of Van Heerden JA in *Edouard* as follows -

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56 *Administrator, Natal v Edouard* 1990 (3) SA 581 (A)

"(T)he "wrong" consists not of the unwanted birth as such, but of the prior breach of contract (or delict) which led to the birth of the child and the consequent financial loss. Put somewhat differently, . . . although an unwanted birth as such cannot constitute a "legal loss" (ie a loss recognised by law), the burden of a parents' obligation to maintain the child is indeed a legal loss for which damages may be recovered."

Goldblatt J noted that in America a claim for 'wrongful birth' is commonly recognised. This claim was first recognised by the Supreme Court of New Jersey in *Berman v Allan*[57]. At p 14 Pashman J said the following:

"The Supreme Court's ruling in *Roe v Wade* clearly establishes that a woman possesses a constitutional right to decide whether her fetus (sic) should be aborted, at least during the first trimester of pregnancy. Public policy now supports, rather than militates against the proposition that she not be impermissibly denied a meaningful opportunity to make that decision. As in all other cases of tortious injury, a physician whose negligence has deprived a mother of this opportunity should be required to make amends for the damage he has proximately caused. Any other ruling would in effect immunize from liability those in the medical field providing inadequate guidance to persons who would choose to exercise their constitutional right to abort fetuses (sic) which, if born, would suffer from genetic defects.(Notes omitted) Accordingly, we hold that a cause of action founded upon a wrongful birth is a legally cognizable claim."

In his view, the reasoning of the American Courts was sound and fitted comfortably within the Aquilian action. The requirements for such an action are a wrongful act committed with the fault (either negligent or intentional) of the defendant which causes the plaintiff to suffer some harm. Goldblatt J held that a doctor acts wrongly if he either fails to inform his patient or incorrectly informs his patient of such information she should reasonably have in order to make an informed choice of whether or not to proceed with her pregnancy or to legally terminate such pregnancy. He said that the fault element of the delict is to be found in the foreseeability of harm which the doctor-patient relationship gives to the doctor. Once proper disclosure is not made and the patient is deprived of her option, the damages she has suffered by giving birth to a disabled child are clearly caused by the fault of the doctor, provided she would have terminated the pregnancy if the information had been made available to her. Goldblatt J found that in regard to her claims in her personal capacity the plaintiff's particulars of claim contained averments sufficient to sustain an action. He stated that this cause of action was a logical extension of the principle enunciated by the Appellate Division in *Edouard*[58].

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57 *Berman* 404 A 2d 8 (1979)

58 *Edouard* fn 56 *supra*

Goldblatt J agreed with the defendant that the plaintiff could neither enter into a contract on behalf of Alexandra prior to Alexandra's birth or at such time make any election on Alexandra's behalf. He said it was trite law that an agent cannot act on behalf of a non-existent principal and that it was similarly trite that legal personality only commences at birth. In these circumstances the allegation that the plaintiff acted on Alexandra's behalf whilst she was still in utero was legally untenable. Further, he said, it could not be argued that this was a contract for the benefit of a third party as such party could only accept the benefit, if it be one, at a time when the alleged benefit, ie termination of pregnancy, was no longer possible. Thus it was necessary to consider whether Alexandra had a delictual claim against the defendant for allowing her to be born with her disabilities instead of giving the plaintiff such advice as would have caused her to terminate her pregnancy and cause Alexandra never to have existed in the legal sense.

Goldblatt J referring with approval to *Pinchin and Another NO v Santam Insurance Co Ltd*[59] noted that the first question to be answered in relation to the delictual claim was whether a person has an action in respect of injury inflicted on him while he was still a foetus in his mother's womb. This question was posed by Hiemstra J in that case and answered in the affirmative. Goldblatt J was of the opinion that in the instant case, at least, it is not necessary to invoke the so-called nasciturus rule because Alexandra's action did not arise when the pregnancy was not terminated, but when she was born. The plaintiff argued that, once the mother is entitled to sue, on the basis that fault and causation are proved, there is no reason in law or logic why a child should not equally be able to sue for its damages, including general damages for pain and suffering, disability, loss of amenities and loss of earnings since these consequence flow directly and foreseeably from the initial delict. Further, the plaintiff submitted that the proper measure of damages is the amount necessary to compensate the child for having to live in a disabled state and not the difference between non-existence and existence in a disabled state. Goldblatt J observed that the action for 'wrongful life' has been considered in a number of American cases and has in the

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59 *Pinchin* 1963 (2) SA 254 (W)

main failed. He referred to the judgment of Cercone J in *Speck v Finegold*[60] where he said:

"In the instant case, we deny Francine's claim to be made whole. When we examine Francine's claim, we find regardless of whether her claim is based on "wrongful life" or otherwise, there is a failure to state a legally cognizable cause of action even though, admittedly, the defendants' actions of negligence were the proximate cause of her defective birth. Her claims to be whole have two fatal weaknesses. First, in appellate judicial pronouncements that hold a child has no fundamental right to be born as a whole, functional human being. Whether it is better to have never been born at all rather than to have been born with serious mental defects is a mystery more properly left to the philosophers and theologians, a mystery which would lead us into the realm of metaphysics, beyond the realm of our understanding or ability to solve. The law cannot assert a knowledge which can resolve this inscrutable and enigmatic issue. Second, it is not a matter of taking into consideration the various and convoluted degrees of the imperfection of life. It is rather the improbability of placing the child in a position she would have occupied if the defendants had not been negligent when to do so would make her non-existent. The remedy afforded an injured party in negligence is intended to place the injured party in the position he would have occupied but for the negligence of the defendant. Thus, a cause of action brought on behalf of an infant seeking recovery for a "wrongful life" on grounds she should not have been born demands calculation of damages dependent on a comparison between Hobson's choice of life in an impaired state and non-existence. This the law is incapable of doing."

Goldblatt J noted that in *Philips v United States*[61] the District Court of South Carolina dismissed a "wrongful life" claim after considering all the then reported American cases on the basis of the fundamental policy of the preciousness and sanctity of human life. They accepted it as basic to the beliefs of society that life, with or without a major physical handicap, is more precious than non-life.

In California in *Curlender v Bio-Science Laboratories*[62] the Court of Appeal allowed a wrongful life claim for damages on the basis that there should be a remedy for every wrong committed. This approach, said Goldblatt J, was in his view illogical and contrary to legal principles in that it ignores the central question of whether a wrong had in fact been committed. He observed that in England the question of whether or not a claim for 'wrongful life' existed was dealt with by the Court of Appeal in *McKay and Another v Essex Area Health Authority and Another*[63] and that the court found that no cause of action existed for a number of reasons.

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60 *Speck* Pa 268 Super 342 (1979); 408 A 2d 496
61 *Philips* 508 F Supp 537 (1980)
62 *Curlender* App 65 Cal Rptr 477
63 *McKay*[1982] 2 All ER 771 (CA)

Firstly, the court held that the defendant was under no duty to the child to give the child's mother an opportunity to terminate the child's life. Whilst such a duty may be owed to the mother it could not be owed to the child.

"To impose such a duty towards the child would, in my opinion, make a further inroad on the sanctity of human life which would be contrary to public policy. It would mean regarding the life of a handicapped child as not only less valuable than the life of a normal child, but so much less valuable that it was not worth preserving. . . ."[64]

The court further held, as had many American courts, that it was impossible to calculate damages being the difference between an impaired life and no life.

"But how can a court begin to evaluate non-existence, 'The undiscover'd country from whose bourn no traveller returns'? No comparison is possible and therefore no damage can be established which a court could recognise. This goes to the root of the whole cause of action"[65]

Goldblatt J said that in his view the reasoning of the American courts holding that no cause of action exists in regard to a 'wrongful life' claim and the very cogent reasoning of the English Court of Appeal along the same lines was correct and agreed both with the conclusions reached and the reasons therefor. He stated that South African law similarly cannot recognise that the facts alleged by the plaintiff on behalf of Alexandra are sufficient to sustain a cause of action. It would be contrary to public policy, said Goldblatt J, for courts to have to hold that it would be better for a party not to have the unquantifiable blessing of life rather than to have such life albeit in a marred way. Further, he said, to allow such a cause of action would open the door to a disabled child being entitled to sue its parents because they may have for a variety of reasons allowed such child to be born knowing of the risks inherent in such decision. Merely to state this proposition is to indicate the unacceptable burden that would be placed on such unfortunate parents. Finally, he said, to allow damages to be claimed on the basis alleged by the plaintiff was completely contrary to the measure of damage allowed for in the law of delict. The defendant was in no way responsible for the child's disabilities and yet he was being asked to compensate the child for such disabilities. This proposition was, in his view, illogical and contrary to the South African legal system. The only measure of damages could be the difference in value between non-existence and existence in a disabled state. No criteria, in law, could

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64 Per Stephenson LJ at 781e

65 Per Ackner LJ at 787h

exist, said Goldblatt J, in establishing such difference or even in establishing whether any damage had been sustained. Accordingly the exception to the plaintiff's claims in her personal capacity was dismissed and the exception to plaintiff's claims in her capacity as mother and natural guardian of her minor child, Alexandra, was upheld and such claims were dismissed.

Discussion

This case illustrates, *inter alia*, the thinness of the barriers between the law of contract and that of delict. The court did not distinguish between issues of public policy with regard to these two branches of law. It considered the question of whether the contract between the plaintiff and the defendant was *contra bonos mores* and found, interestingly with reference to statutory law, that it was not. The court's reference to the provisions of a relevant statute in order to establish public policy is commendable and makes for consistency within the legal system as a whole. If it had found that the contract was *contra bonos mores* then there would have been an inexplicable and logically unacceptable divide between statutory and common law. In its judgment the court effectively upheld the contractual claim of the mother but denied the delictual claim of the child. The claim of the mother was, however, equally at home in the law of delict and the court did not specifically decide this claim on the basis of the law of contract or of delict but rather simply dismissed the exceptions to the claim of the mother raised by the defendant. It allowed the claim in contract in that it found that the contract was not *contra bonos mores* but it also did not preclude the claim based in delict. The question arises whether a claim in delict would have been viable had the contractual claim been found to be *contra bonos mores*. It is an interesting question because it addresses the relationship between these two areas of law. If the court had found that the defendant could not enter into an agreement in terms of which a pregnancy would be terminated should the foetus be found to be defective, then could it still have been said that there existed a duty of care, in terms of the law of delict, to inform the mother that the foetus was defective so that she could terminate the pregnancy? It is submitted that the answer is no. How can the exact same duty in terms of the law of delict be upheld when the contractual one is denied on the basis of public policy? Public policy does not change from one branch of the law to the other in these circumstances. Either the termination of pregnancy is wrongful or it is not. If

it is not, then a contract contemplating such termination is lawful and there is a concomitant legal duty in delict to provide medical advice with a view to determining the necessity of the termination. It is submitted that in the context of health care service in particular, this kind of indivisibility between the law of contract and the law of delict is particularly evident due to the nature of the services provided. The court used the limitation of liability argument to preclude a claim for wrongful life in terms of the law of delict. Strauss[66] writing in 1991 observes that it is still an open question whether South African courts will uphold a claim for wrongful life and that different policy considerations may apply in respect of such a claim. He notes that liability for wrongful life is a completely different story to claims for wrongful conception and refers to Giesen[67] who has pointed out that claims by the infants themselves have been regarded almost universally with disfavour. Giesen comments that the child is not claiming that the physician's negligence caused its defects but that had he informed its parents properly, it would never have seen the light of day at all. And the courts have refused on policy grounds to hold that life, even if experienced with severe handicaps, is or can be preferable to non-existence. The unarticulated conundrum in these cases, it is submitted, rests in the fact that the purpose of a contractual award of damages is to place the victim in the position in which he or she would have been but for the breach. In the present context, taken to its logical conclusion it means to compensate a person for the fact that he or she did not die. Effectively, therefore, it means awarding damages for a death that did not occur and is rather more an attempt to quantify the value of death, or non-existence, that it is to quantify the 'loss' arising from a disabled life. Similarly, in terms of the law of delict, the object is to place the plaintiff in the position in which she would have been but for the wrongful act or omission of the defendant. In this instance, it would mean killing the plaintiff. This goes contrary to public values and the legal convictions of the community with regard to life. It is mirrored in the attitude of the South African law to euthanasia. A plaintiff would not be able to bring an action in delict against a doctor who failed to euthanase him as requested, either on the basis of a contract or in terms of the law of delict, since to cause or hasten the death of another, even if he or she is in any event dying, is wrongful in terms of the legal convictions of the community. Any legal developments

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66 Strauss fn 24 *supra* at p 175, 179 -180 and p 197-198

67 Giesen D, *International Medical Malpractice Law*

in favour of euthanasia would of logical necessity have to give rise to a review of the legal position in the case of wrongful life claims since in principle there is no difference between the two except that they usually occur at two different ends of the human lifespan. Strauss[68] comments that judging by the views expressed by South African jurists, it is highly unlikely that 'wrongful life' claims will be upheld by South African courts as a cause of action. It turns out that this view was validated by the judgment in Friedman's case. Claassen and Verschoor[69], also writing prior to *Friedman*, note that in *Gleitman v Cosgrove*[70] the first wrongful life claim was instituted by a disabled child. The mother contracted rubella during the first three months of pregnancy and she was assured by the defendant paediatrician that the illness would have no prejudicial effect on her unborn child. On the strength of this advice she decided not to have an abortion. The child was subsequently born with brain damage and seriously defective sight, speech and hearing. Both the parents' and the child's unlawful life claims were rejected by the court. The court contended that no parallel could be drawn between human life and a state of non-existence and further that any life in any form whatsoever, was to be preferred to non-life. They also refer to *Stewart v Long Island College Hospital*[71] and to the case referred to by Goldblatt J in *Friedman*, *Berman v Allen*[72]. Claassen and Verschoor canvass the reasons for rejecting a claim for damages on the basis of wrongful life[73] and note that Brownlie[74]disagreed with Strauss that South African courts were likely to reject a claim for wrongful life.

Although, as the court pointed out with reference to *Pinchin*, injuries done to a foetus while in the womb do attract liability in terms of the law of delict, the point in this case seems to be that if the doctor did not cause the disability in the first place, he or she should not be held liable for the birth of a child with that disability. It was not

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68 Strauss fn 24 *supra* at p 197

69 Claassen NJB and Verschoor T, *Medical Negligence in South Africa* at p 85

70 *Gleitman* 227 A 2d 689, NJ 1967

71 *Stewart* 58 Misc 2d 432, 296 NYS 2d 41 (NY Sup CT 1968) in which Mrs Stewart, on the advice of her physician decided to have an abortion after having contracted rubella during the early stages of her pregnancy. The hospital panel which had to authorize the abortion decided against it and consequently the child was born with certain handicaps. The child and the parents sued for negligence and the child's claim was rejected because "... there is no remedy for having been born under a handicap, whether physical or psychological, when the alternative to being born in a handicapped condition is not to have been born at all. To put it another way, a plaintiff has no remedy against a defendant whose offense is that he failed to consign the plaintiff to oblivion."

72 *Berman* fn 57*supra*

73 Claassen and Verschoor fn 69 *supra* at p91 to 93

74 Brownlie S 1985 'Wrongul Life: Is it a Viable Cause of Action in South Africa?' *Responsa Meridiana* 5(1): 18-35

something he could have prevented except by killing the foetus and there is insufficient evidence that this last is any kind of solution in any event. There is a certain symmetry between the wrongful birth situation and the situation in *S v Williams*[75] where the accused tried to argue that the act of taking the patient off the life-support system was a *novus actus interveniens* that caused her death and as opposed to the assault on the deceased by the accused. In the wrongful life situation the birth was inevitable according to the natural course of events just as the death in *S v Williams*[76] was inevitable due to the natural course of events. In both situations the medical intervention that was required was supposed to avoid the anticipated outcome and divert the natural course of events from its logical conclusion. The difference is that in wrongful birth cases that logical conclusion is birth whereas in *S v Williams*[77] it was death. The two cases are consistent in terms of their logical symmetry in that the courts in both cases rejected the idea that the failure to divert the natural course of events from its logical conclusion was unlawful. However these two cases are at the two extreme ends of a health care spectrum. In the middle of the spectrum and, in all likelihood to the majority of cases involving health care delivery, the opposite rule applies as illustrated by the Volkmann's contracture cases[78] and the sterilisation cases[79]. In these cases the judgments of the court went against medical practitioners who failed to reasonably avert the consequences of the natural course of events. This apparent logical inconsistency need not necessarily be a problem since there are other examples of logical systems in which the rules that apply generally start to break down or have a different effect at extreme ends of a spectrum.[80] It can also be argued that at the extreme ends of the spectrum the rights of the health professionals themselves and boundaries of reasonableness are more prominent features of the logical system. For example in cases involving the termination of pregnancy, the constitutional right of the health professional to freedom of conscience, religion, thought, belief and opinion starts to weigh in against the right to have a pregnancy

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75 *S v Williams* 1986 (4) SA 1188 (A). It was held that where a person is wounded so seriously that it would, in the absence of prompt medical intervention, very soon lead to his death, and such person is kept alive artificially by means of a breathing apparatus (a respirator), the eventual disconnecting of the respirator cannot be seen as the act causing death. It is merely the termination of a fruitless attempt to save the life, ie a fruitless attempt to avert the consequences of the wounding. The causal connection between the wounding of the deceased and his eventual death exists from beginning to end and is not interrupted and eliminated by the disconnecting of the respirator.

76 *Williams* fn 75 *supra*

77 *Williams* fn 75 *supra*

78 *Dube v Administrator Transvaal* 1963 (4) SA 260 (W) and *Blyth v van der Heever* 1980 (1) SA 191 (A)

79 *Mukheiber v Raath And Another* 1999 (3) SA 1065 (SCA) and *Administrator, Natal v Edouard* fn 56 *supra*

80 An obvious example that springs to mind is the field of physics in which there are a number of examples most notably in the field of quantum physics but also at temperatures approaching absolute zero.

terminated. Similarly the reasonableness of the expectation to be snatched from the jaws of death or to be consigned to oblivion before consciousness takes hold sits at the outer limits of human capacity to decide what is in fact reasonable.

In the case of *S v Williams*[81] the court took the view that it is sometimes just not possible, despite every effort, to divert the natural course of events and that it does not lie within the mouth of the person who set that course of events in motion to say, when it reaches its logical conclusion, that someone else must be held liable for it.

In the health care context, the right of the a newborn dependant of a member of a medical scheme to benefit from that medical scheme is a more common example of similar boundary issues in the law of contract as it applies to health care services. A person is a member of a medical scheme and as such is entitled to certain benefits not only for him- or herself but also her registered dependants. The basis of the member's relationship with the medical scheme lies in the law of contract[82]. Maternity benefits in respect of confinement costs for the pregnant mother and any medical treatment that may be necessitated by the birth process and attendant complications are usually offered by medical schemes. The baby is not yet born. It is not yet a dependent in its own right independent of its mother. Nonetheless, while the unborn child is in the mother's womb, it can be given medical treatment that is specifically intended to address the health problems of the child and not the mother. An extreme example of such treatment is *in utero* surgery on the unborn child to correct conditions such as spina bifida, congenital diaphragmatic hernia and heart defects[83]. Since in South African law a foetus is not a person[84] and only persons have contractual capacity, any

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81 *Williams* fn 75 *supra*

82 It may be a highly regulated contract in terms of the Medical Schemes Act No 131 of 1998, but it is still a contract.

83 Johnson K 'Fetal Surgery and Option for a Range of Diagnoses' *OB/GYN News* August 1, 2000 notes that as prenatal diagnostic techniques become increasingly sophisticated, options for fetoscopic as well as open fetal surgery are rapidly evolving as well according to Dr T Crombleholme in a meeting of the Society for Obstetric Anaesthesia and Perinatology. Dr Crombleholme stated that: " We see a whole range of fetal problems, from choroids plexus cysts, to agenesis of the corpus callosum, complicated by CNS problems, sacrococcygeal teratoma, obstructive uropathy and even myelomeningocele, which is somewhat controversial because for the first time we are trying to treat a nonlethal condition." According to Dr Cromblehome about 10% of patients need to have a procedure done in utero but the vast majority of conditions can be managed postnatally. Among the procedures performed at the Center for Fetal Diagnosis and Treatment at Children's Hospital of Philadelphia and the University of Pennsylvania is in utero treatment of congenital diaphragmatic hernia and congenital cystic adenomatoid malformation.

84 *Christian Lawyers Association of SA and Others v Minister of Health and Others* 1998 (4) SA 1113 (T). In this case the court held that he answer to the question of whether a foetus has a right to life did not depend on medical or scientific evidence as to when the life of a human being commenced and the subsequent development of the foetus up to the date of birth, nor was it the function of the Court to decide the issue on religious or philosophical grounds. The issue was a legal one to be decided on the proper legal interpretation of s 11 of the Constitution. The court noted that, as "pointed out by Professor Glanville Williams in an article entitled 'The Foetus and the Right to Life' (1994) 33 *Cambridge Law*

contracts relating to such treatment cannot be with the foetus itself or even, as a *stipulatio alteri*, for the benefit of the foetus while still in its mother's womb. Similarly the obligation of a medical scheme to provide benefits to a foetus in respect of such treatment cannot be with the foetus itself.[85] In the context of medical scheme

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Journal 71 at 78 'the question is not whether the conceptus is human but whether it should be given the same legal protection as you and me'." McCreath J continued as follows: "In *Van Heerden and Another v Joubert NO and Others* 1994 (4) SA 793 (A) the Appellate Division of the Supreme Court (as it then was) considered various dictionary meanings of the word 'person' (inter alia 'an individual human being') and concluded (at 796F) that there is no suggestion in any of these meanings that the word 'person' can also connote a stillborn child, an unborn child, a viable unborn child, an unborn human being or a living foetus. The Court went on, however (at 797H–798B) to point out that there are a growing number of jurists who hold the view that the application of the nasciturus pro iam nato habetur quotiens de commodo eius agitur rule of the Roman law amounts to predating the legal subjectivity of the foetus. Thus, P J J Olivier Legal Fictions: An Analysis and Evaluation (Doctoral Thesis, Leiden) and L M du Plessis 'Jurisprudential reflections on the status of unborn life' 1990 *TSAR* 44 maintain that the foetus is recognised as a legal persona and is protected as such. As pointed out by Professor Du Plessis, the decision in *Pinchin and Another NO v Santam Insurance Co Ltd* 1963 (2) SA 254 (W), in which a person's right to claim, after birth, compensation for injuries sustained in ventre matris, was recognised, makes sense only if it is assumed that that person was indeed in law a persona at the time when the injuries were sustained. The status of the foetus under our common law was left open in Van Heerden's case *supra*. The Appellate Division decided that, even if it is to be assumed that a stage has been reached in our legal development where the law recognises the foetus as a legal persona, the Legislature had no such legal persona in mind when it used the word 'person' in the legislation there under consideration, namely the Inquests Act 58 of 1959. There are South African decisions denying the foetus legal personality - see *Christian League of Southern Africa v Rall* 1981 (2) SA 821 (O) at 829 in fin; *Friedman v Glicksman* 1996 (1) SA 1134 (W) at 1140G. It is not necessary for me to make any firm decision as to whether an unborn child is a legal persona under the common law. What is important for purposes of interpreting s 11 of the Constitution is that, at best for the plaintiffs, the status of the foetus under the common law may, as at present, be somewhat uncertain."

85 In *Ex Parte Oppel And Another* 2002 (5) SA 125 (C) the court referring to *Wolman and Others v Wolman* 1963 (2) SA 452 (A), observed that generally, a minor cannot conclude legally binding contracts unassisted. Likewise, the minor cannot institute legal proceedings without the assistance of his guardian. A parent can contract on behalf of a minor child in certain circumstances. Christie *The Law of Contract* at p 264-265 notes that a person is a minor, in terms of the Age of Majority Act No 57 of 1972, until he or she reaches the age of 21 or marries or is emancipated either under the 1972 Act or tacitly. A child under the age of 7 years has no contractual capacity at all so the only contracts that can be binding on him are those made by his guardian on his behalf. (See Voet 26 8 9). The court in *Ten Brink No and Another v Motala and Others* 2001 (1) SA 1011 (D) the court stated that: "Counsel for the applicants contends, however, that where a person such as the second respondent signs in a representative capacity, that fact must appear *ex facie* the document itself. The contention cannot be sustained because in *Cook v Aldred* 1909 TS 150, Innes CJ had said (at 151): 'Though a contract purport to be entered into in the name of the agent, parol evidence may be led to show that it was entered into on the principal's behalf. Such evidence does not in truth vary the written contract, because the liability of the other party to the contract remains. It simply informs the Court that some other person is entitled to sue upon it, and that the principal desires to enforce his rights under it.'
If such evidence is permissible in the case of an agent, then the same must *a fortiori* apply to the case of a father and natural guardian signing on behalf of his minor child. Counsel's contention is in any event in conflict with the decision in *Van der Merwe v Kenkes (Edms) Bpk* 1983 (3) SA 909 (T), where a woman married out of community of property had sued on a contract for the purchase of fixed property. Her husband had signed the contract on her behalf without qualifying his signature, and it was held that extrinsic evidence would be admissible to prove that in signing the contract her husband had acted on her behalf. Counsel submits that the matter is otherwise in the case of a father signing on behalf of his minor child, but in my judgment there is no difference in principle."
In *Visser v Van Tonder* 1986 (2) SA 500 (T) the court observed that a contract with a minor is an example of a limping contract with reference to *Edelstein v Edelstein NO and Others* 1952 (3) SA 1 (A)). However, Christie RH *The Law of Contract* at p270 points out that minor's unassisted contracts which call for performance only from the other party and not from the minor are also enforceable. Christie quotes the dicta of Van den Heever JA in Edelstein as follows: "It will be observed that Grotius does not say that in the exceptional cases mentioned by him the contract of a minor is valid. He approaches the matter from the point of view of obligations. In general, he states, a minor cannot assume an obligation; if he purports to do so, the obligation is not enforceable. Grotius mentions two relevant exceptions: (1) a minor may validly stipulate for an advantage and (2) …What is meant by the former is perfectly clear from our authorities: an unassisted minor cannot validly make a promise to perform; he may, however, stipulate for a performance by the other party to the transaction. The type of stipulation appears from van der Keessel (*Dictata ad Grot.* 1.1.8): an unassisted minor may validly accept a donation or stipulate that a valid claim against himself be not enforced." Christie says that that only quibble one can have with that passage is that it makes Grotius state the general rule in the form "a minor cannot assume an obligation; if he purports to do so the contract is not enforceable." Why then, one might well ask, is Grotius' first exception an exception since it does not involve the assumption of an obligation by the minor? The answer is that that is not how Grotius states the general rule, so his first exception is a true exception to the rule as stated by him. What Grotius says (1 8 5) according to Christie is: "any contract entered into by minors unassisted, even though confirmed by oath, has no binding force (*buiten rechts-dwanck*) as unknown to the civil law: except that they may stipulate for something to their advantage". A contract in terms of which a medical scheme is obliged to fund within the scope of its registered rules, the health care expenses of a minor child could arguably be seen as creating a contractual obligation between the scheme and that minor child because it is not the minor child that is obliged to pay the contributions but the principal member. There is no obligation on the minor child as such but there is an obligation upon

membership it may be argued that the relationship between a scheme and its members is not contractual but it is submitted that this argument is likely to succeed only in the most limited of circumstances[86]. A member is entitled to register dependants with his medical scheme so that they too may receive benefits in terms of the scheme rules.

A number of questions arise in relation to the law of contract as applicable in this context. What, if any, is the obligation of a medical scheme to pay for *in utero* surgery? Is it on the basis that the foetus is still technically a part of the body of the mother since it has no separate and independent existence of its own? Assuming that a diligent father as principal member ensures that his newborn child is registered as a dependant on his medical a scheme on the day of its birth, what is the relationship in law, if any, between the medical scheme and the infant? What is the legal relationship between the health professional and the foetus upon which he or she operates while the latter is *in utero*? From a legal perspective, is the foetus simply a part of the mother's own body until it is born? If it is simply a part of the mother's body until it is born, does the father have any say over whether or not *in utero* surgery should be conducted despite the fact that if a disabled child is born it will be as much his responsibility to maintain and care for the child as it will be that of the mother? If it is not regarded simply as a part of the mother's body until it is born then on what legal basis is its independent existence justified given that, in terms of South African law, it is not a person until it is born? Because surgery *in utero* is at the forefront of medical science, the law relating to this issue is also largely undeveloped. It has been observed that one of the features of bioethics in the late 1900s was a rolling debate over surgery on foetuses still in the womb, a procedure conducted at only three institutions in the United States. When a programme chose to develop a surgical intervention for foetuses whose spina bifida defects were not lethal, much attention was focused on the difficulty of developing fetal surgery and on its ethical implications. Specifically, many wondered who the patient of foetal surgery should be, the foetus or the mother, since the foetus has no standing under US abortion law. Some argued that there is no

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the scheme to pay the medical expenses of that child. This argument in the context of a medical scheme weakens in the face of the alternative argument that the contract is with the principal member alone since this person has a legal obligation to ensure the provision of health care services to his or her minor children and so it is a function of the parent's duty of support.

86 Where for instance membership of a medical scheme is not dependent upon the will or intention of the member to become a member and to be contractually bound to pay contributions to the scheme in return for funding of health care expenses.

room for this kind of surgery on foetuses as they cannot give consent. Development of fetal surgery promises to be a major source of new therapy and to increase pressure on policymakers and ethicists to define the difference between responsibilities to women and to future children[87]. American courts have encountered some problems with the question of the legal basis on which to protect a foetus both from its own mother and from third parties. Prosecutors and judges in numerous states have begun to apply child abuse, neglect, support, endangerment and homicide statutes in an attempt to deter, punish or remedy maternal conduct during pregnancy deemed harmful to the unborn child. Many prosecutors and judges have relied on statutory authority when requiring pregnant women to undergo medical procedures thought "necessary to preserve fetal life or health"[88]. It is clear that the closer the law comes to attributing a duty upon a mother, or to other persons, to act in a certain way towards an unborn child, the more significant become the contractual obligations between a parent and a third party for the benefit of that unborn child[89]. From there it is a small logical step to recognising certain obligations to an unborn child directly. This chain of legal development however, is on a collision course with the notion that the unborn child is not a person. In South African law, the nasciturus rule at this stage applies only in the law of delict and the law of succession. It has not been extended to other areas of law. The question is whether, in the context of the law of contract, there is any substantial logical reason not to. The court in *Friedman v Glicksmann*[90] used the possibility of a child's suing its parents as one argument in favour of precluding a claim for wrongful

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87 McGee G 'Bioethics At The End Of Yhe 1900s' *MSNBC Breaking Bioethics* Bioethics .net http://www.bioethics.net/msnbc

88 See Cook M 'From Conception Until Birth: Exploring the Maternal Duty to Protect Fetal Health' *Washington University Law Quarterly* vol 80 p 1307 at p 1309 and the authorities there cited. See also Rauscher K 'Fetal Surgery: A Developing Legal Dilemma', 31 *St Louis University Law Journal* p 775.

89 Cook fn 88 *supra* uses two case examples at the beginning of his article that dramatically illustrate the problems the law runs into in the context of balancing the interests of the mother against those of her unborn child. "Kawana was in her third trimester of pregnancy when someone show her in the abdomen in an attempt to kill the child developing within her womb. Shortly thereafter, paramedics rushed Kawana to the hospital where an emergency surgery saved her life. However, the bullet managed to obliterate the tiny child's wrist, and, as a result, the doctors were required to perform an emergency delivery. Kawana'c child grasped on to life for fifteen days before dying, its immature life extinguished as a result of the premature birth. Likewise Rena was pregnancy when an attacker kicked and stabbed her in the abdomen in an attempt to kill her unborn child. After the assault, paramedics transported Rena to a local hospital where doctors successfully treated her life-threatening injuries. However, the fetal monitor indicated trouble for the unborn child. Doctors quickly performed an emergency caesarian section in an attempt to save the dying child's life. Unfortunately, Rena received too great a trauma for the child to withstand. A medical examiner found that her child lived for only ten minutes. Although the facts of these two scenarios were similar, the legal outcomes were not. In the first example, the child's mother fired the gun into her own abdomen, attempting to kill her unborn child. In *State v Ashley* [701 So. 2d at 338 (Fla. 1997)] the Florida Supreme Court upheld the common law rule that provided immunity to a pregnant woman for causing the death of her foetus. However in *United States v Spencer* 839 F. 2d at 1341, because the attacker was not the mother, the court reached a different result. Although the child survived for only ten minutes, it was considered, as the Spencer court articulated, the "killing of a human being". Despite the fact that each child was born alive in both of these examples, the two cases illustrate a discrepancy found in both the United States' federal and state judicial systems regarding the woman and her foetus. Namely even though a third person may be held criminally liable for causing injury or death to a foetus, the unborn child's mother may not."

90 *Friedman* fn 53 *supra*

life. Whilst the writer is not arguing in favour of claims for wrongful life, whether based in delict or on a contract, the question is whether a child's capacity to sue its parents is problematic in terms of the legal convictions of the community? Child abuse is a delict as much as it is a crime. In South Africa in particular, children unfortunately need all the legal protection against abuse that they can get. Cook[91] notes that courts have increasingly grappled with the subject of whether a woman has a maternal duty to guarantee the health of her foetus. As a result of these decisions prenatal tort liability has not developed primarily during the last few decades to the point where children may now bring personal injury actions against their mothers for harmful prenatal conduct. Cook points out that at the core of these personal injury actions is the belief that a child has "a legal right to begin life unimpaired by physical or mental defects caused by another's negligence. From the cold logical perspective, an unborn child that is dead as the result of an abortion cannot bring a delictual claim for harmful prenatal conduct because it is dead and it never became a person in the eyes of the law. The conundrum is that if the abortion fails and the child is born injured, it can. The writer has already pointed out the thinness of the boundaries between contractual and delictual obligations in the context of health care. It is submitted that in the context of the law of contract, to state that a foetus is not entitled to benefit from contractual obligations in its favour imposed upon a third party by its parents is no different to saying that a neonate is not entitled so to benefit. A contract for health care services is not enforceable on behalf of a foetus but it is enforceable on behalf of the neonate. The American system also recognises a rule similar to the nasciturus rule in South Africa. In general when an injured foetus is born alive, the child or those acting on behalf of the child may maintain an action to recover damages for negligently inflicted prenatal injuries caused by third parties[92]. There seems to be no major differences in principle on this subject between the American legal system and our own. The writer has already pointed out that South African courts tend not to be too pedantic when faced with claims in delict and in contract in situations involving health care services where the cause of action is fundamentally the same. They have a tendency to end up resolving the case on the basis of the law of delict

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91 Cook fn 88 *supra*

92 Cook fn 88 *supra* at p 1313. He points out at p 1314 that: "In the legal realm, allowing for recovery for prenatal injury to a foetus later born alive has become the "universal rule". For instance, during the last fifty years, virtually all jurisdictions have recognized tort actions against third parties for the infliction of prenatal injuries when the child is subsequently born alive."

rather than the law of contract but seem not to be unduly concerned with the finer distinctions between the law of contract and the law of delict. It is submitted that these finer distinctions are in any event becoming increasingly still finer over time. The question of contractual capacity when one is dealing with health service delivery to minors is no big hook upon which an analytical lawyer should get hung up when considering health services to children in view of the provisions of section 28(1)(c) section 28(2) and section 27(1) of the Constitution. The law of contract holds an agreement with an unassisted minor binding when it is purely to the advantage of that minor and when no reciprocal obligations are imposed on the minor him- or herself. Similarly a parent can assist a child to enter in to a contract which is then also binding upon both the minor and the third party. In other words, contracts with minors are legally, technically possible despite the fact that they have no contractual capacity. In this sense, therefore, it is difficult to distinguish between a minor and a foetus. When it comes to the legal position of the unborn child, despite the fact that is not yet a person in the eyes of the law, the position is not as clear cut as it would first appear. The law does recognise, albeit in roundabout ways, the need to protect an unborn child. The application of the nasciturus rule in the law of delict and the law of succession is an example of this. Cook notes that the question of whether courts may convict the slayer of a foetus under homicide statutes has been the subject of controversy for many years. He states that at common law and in the absence of a statute, there is no crime of a child dies before birth. However, under many state statutes today, if the child is born alive and later dies, the culpability is the same as that incurred in the killing of any other human being. The rationale is that a child who has an "independent existence" separate from his or her mother is a human being. Cook[93] observes that recently courts have provided that damage inflicted in a foetus *in utero* is sufficient to support a homicide charge even without a live birth. At the federal level, feticide statutes are receiving growing attention. Under the Unborn Victims of Violence[94], United States attorneys can charge individuals who commit an already defined federal crime of violence against a pregnant woman with a second offence on behalf of the second victim, the unborn child. Currently the majority of states already have "unborn victim laws". It would seem that of late the American

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93 See Cook fn 88 *supra* at p1320 to 1322.

94 Unborn Victims of Violence Act of 2001

legal position with regard to an unborn child, to which Grosskopff JA referred in *Van Heerden and Another v Joubert No and Others*[95] has changed and continues to do so[96] without necessarily conferring personhood on a foetus. In the context of health care services to a foetus Cook notes that the federal government has calculated that the average healthcare costs of a drug-exposed foetus total about one million dollars.

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95 *Van Heerden* 1994 (4) SA 793 (A)

96 Grosskopff JA noted: "In the case of *Roe v Wade* 410 US 113 (1973) the Supreme Court was called upon to decide on the constitutionality of the Texas criminal abortion laws. In the course of the argument it was submitted that a foetus was a 'person' within the language and meaning of the Fourteenth Amendment, but the majority of the Court (at 156-8) was not persuaded that the word 'person' also included the unborn. In *R v Tait* [1990] 1 QB 290 (CA) the Court of Appeal held that a threat to a pregnant woman to kill her foetus was not a threat to kill a 'person' under the Offences against the Person Act 1861. I am likewise of the view that the word 'person' in the context of the present Act does not include an unborn child. Cook (fn 88 *supra*) notes that subsequent to the Roe decision, state courts have upheld convictions under general homicide statutes for the death of an unborn, viable foetus. In other jurisdictions, however, the courts have held that prosecutors may maintain a conviction under general homicide statutes only if the legislature defines a foetus as a "person" or "human being" under the terms of the statute. Not surprisingly, says Cook, courts continue to debate over a parent's legal obligation to protect fetal health. In 1931 the court in *People v Yates* [298 P. 961 (Cal. Dist. Ct. App. 1931) resolved the issue of whether prosecutors could successfully charge a father with neglect of his unborn child. The father in *Yates* failed to furnish food, clothing, shelter and other medical attendance to his unborn child's mother. The court held that the father had a duty to provide these necessary things to ensure the health of his unborn child by providing them for the mother. Almost seventy years later, the South Carolina Supreme Court in *Whitner v South Carolina* [492 S.E. 2d at 777] addressed whether the state could prosecute a mother for neglecting her unborn child. The unborn child's mother ingested crack cocaine during her pregnancy and the state brought criminal neglect charges against her for her conduct. The Whitner court became the first high court of any state to hold that a viable foetus is a person within the meaning of its state child abuse laws. As a result of this decision, some commentators have argued that health and social services professionals must guess whether a pregnant woman's failure to obtain prenatal care, to quit smoking or drinking, to stop taking over-the-counter medicine, or to refrain from playing rigorous sports constitutes unlawful behaviour.
There is a clearly a contrary view to the subject of 'foetal rights' that largely favours the interests of the mother over the unborn child. Martin S and Coleman M in 'Judicial Intervention in Pregnancy' *McGill Law Journal* Vol 40 p 947 for instance postulate that judicial intervention in pregnancy is one of the means by which control is legally exercised on women's bodies and lives. They note that despite the recommendations of the Royal Commission on New Reproductive Technologies which rejected proposals for intervention, and the fact that the movement to recognize foetal 'rights' has been stronger in the United States than in Canada, these proposals nevertheless pose a subsisting threat to women and that women's right to equality in particular, is compromised. They observe that in the United States there have been many cases of women forced to undergo Caesarian sections or subjected to criminal sanctions or civil liability for their conduct during pregnancy. They also caution against being overconfident that this is purely an American problem since judicial intervention, legislation, mental health considerations and academic literature in Canada all mirror the American position albeit to a lesser extent. The recommendations of the Commission with regard to judicial intervention in pregnancy and birth are interesting. They read: "273. Judicial intervention in pregnancy and birth not be permissible. Specifically, the Commission recommends that (a) medical treatment never be imposed upon a pregnant woman against her wishes; (b) the criminal law, or any other law, never be used to confine or imprison a woman in the interests of her foetus; (c) the conduct of a pregnant woman in relation to her foetus not be criminalized; (d) child welfare or other legislation never be used to control a woman's behaviour during pregnancy or birth; and (e) civil liability never be imposed upon a woman for harm done to her foetus during pregnancy. 274. Unwanted medical treatment and other interferences, or threatened interferences with the physical autonomy of pregnant women be recognized explicitly under the *Criminal Code* as criminal assault." The authors point out that the majority of the Commissioners expressly rejected claims to assimilate the position of an unborn foetus to that of a born child and refused to create and impose special legal obligations on pregnant women. They stated that medical treatment should "never" be imposed upon a pregnant woman against her wishes and that child welfare or other legislation should "never" be used to control a woman's behaviour during pregnancy or birth. It is submitted that in South Africa, in constitutional terms, there is no such thing as a fetal right. Although the constitutional rights of a pregnant woman to bodily and psychological integrity are unquestionable and would in the majority of cases take precedence over the interests of her foetus, they are also not absolute and can be limited in terms of section 36 of the Constitution by a law of general application. It is submitted that there are instances where the law should protect the foetus in the interests of the constitutional values of human dignity, equality and freedom. These instances may be narrowly restricted for instance to acts and omissions which, were they in relation to a child, would be unlawful in the criminal sense. For example it may be argued a pregnant woman who seeks to terminate her pregnancy outside of the provisions of the Choice on Termination of Pregnancy Act, her actions should be subjected to some form of legal sanction if there are no good grounds for her failure to make use of the facilities provided for in the Act and as a result of her actions, a disabled child is born subsequently. It is further submitted that a pregnant woman stands in unique relation to her unborn child and that it is reasonable to justify on this basis, a distinction between the manner in which the law treats her acts and omissions in relation to her unborn child and how it treats those of third parties in relation to that unborn child. In other words the 'rights' of a foetus, if such they be, should not be regarded as the same in relation to its mother as they are in relation to others. This is because the foetus and its mother effectively share the same physical body and their interests are thus uniquely and inseparably intertwined.

When a woman exposes her foetus to drugs, hospital charges for the infant are almost four times greater than they are for drug-free infants. Commentators have therefore urged that the state should provide adequate medical care for foetuses that will be brought to term. Accordingly, President George Bush announced a plan that would allow states to provide pre-natal care to low-income women thus recognizing the right of a foetus to receive adequate medical care. It has been argued that after a foetus reaches viability the state should be permitted to prohibit a woman from engaging in certain types of maternal conduct, such as the use of tobacco, alcohol and illicit drugs, when such use presents a serious risk of harm to her unborn child. Advocates of state intervention argue that the child has an interest not to be injured and this outweighs the woman's interest in using both illegal and legal drugs during pregnancy. Moreover, says Cook, the state has a compelling interest in protecting potential human life throughout the woman's pregnancy. Thus the state has a compelling interest in protecting potential human life just as it has a compelling interest in preserving the life itself. If the public policy position in South Africa is the same, and there is no reason to believe that it is not, and it is the same public policy that informs both the law of contract and that of delict then it is not difficult to see the direction in which South African law is headed. The Constitution has highlighted the importance of public policy in South African law and, it is submitted, even elevated it to a position of cardinal importance over more mundanely technical considerations such as contractual capacity, questions of the appropriate barriers to be drawn between the various branches of law such as public and private and between different areas of law such as delict and contract, and indeed even the legal concept of personhood. It promotes a preoccupation with justice as much, if not more than, law itself. Whilst a South African court has held that the Constitution does not regard the foetus as a person, this does not mean that it is not human and that the underlying values of the Constitution, notably human dignity, equality and freedom do not have relevance in the context of foetal medicine. It would defeat the ends of justice to hold that although what happens to a foetus has the capacity to profoundly affect its capacity to exercise and enjoy fundamental human rights once it is born, acts and omissions affecting it whilst still in its mother's womb cannot be subjected to legal sanction and there is no compelling interest on the part of society, in the protection of the unborn. Consequently a medical scheme should not be permitted to argue in terms of the law of contract, that simply because a foetus is not yet a person, and therefore cannot be

registered by a member as his or her dependant, its contractual obligations do not extend to payment of the costs of foetal surgery or other medical treatment of the foetus where such surgery or other medical treatment does not directly benefit the mother herself. Similarly a medical doctor who contracts to perform a certain procedure upon a foetus in utero for the benefit of that foetus should not be able to argue, in the absence of a claim in delict, that he or she had no contractual obligation to the foetus because it was not a person and that the child once born, cannot take legal action for breach of a contractual obligation that occurred while it was still in its mother's womb. If needs be the nasciturus rule should in certain circumstances be applied within the law of contract, to ensure that society's interests in the protection of potential human life are upheld. In the context of the law of succession a stipulation in a will in favour of an unborn child is enforceable by that child once he is born alive. It could be argued that the only reason that a will is not a contract is because it comes into operation upon the death of the testator and not beforehand. Whilst technically speaking, the dead cannot contract with the living, practically speaking they can, provided that there is someone in the land of the living who is able and willing to enforce that contract for the benefit of the living. The point is that practically speaking, there is not much difference in practical terms between a stipulation in a will for the benefit of an unborn child and a stipulation in a contract for the benefit of an unborn child.

Contracts for the benefit of a third person are possible in law but they generally have the result that when the third person accepts the benefit, he or she becomes a party to the contract[97]. Thus the court in *Friedman*[98] held that a mother cannot claim, as mother and natural guardian of her abnormal or disabled child, general damages and loss of future earnings from the doctor who agreed to advise the mother, when pregnant, whether she was at greater risk than normal of having an abnormal or disabled child, so that she could make an informed decision whether or not to terminate her

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97 The court in *Wimbledon Lodge (Pty) Ltd v Gore No And Others* 2003 (5) SA 315 (SCA) noted that in *Joel Melamed and Hurwitz v Cleveland Estates (Pty) Ltd; Joel Melamed and Hurwitz v Vorner Investments (Pty) Ltd* 1984 (3) SA 155 (A) at 172B - D Corbett JA quoted the following passage in *Crookes NO and Another v Watson and Others* 1956 (1) SA 277 (A) at 291E - F with approval: '(T)he typical contract for the benefit of a third person is one where A and B make a contract in order that C may be enabled, by notifying A, to become a party to a contract between himself and A. What contractual rights exist between A and B pending acceptance by C and how far after such acceptance it is still possible for contractual relations between A and B to persist are matters on which differences of opinion are possible; but broadly speaking the idea of such transactions is that B drops out when C accepts and thenceforward it is A and C who are bound to each other.'

98 *Friedman* fn 53 *supra*

pregnancy, and who incorrectly informed her that she was at no greater risk than normal. There can be no claim in contract because the child's legal personality only commences at birth and a principal cannot claim on behalf of a non-existent principal and also because the agreement cannot be a contract for the benefit of a third party since the third party could only accept the alleged benefit, i.e. the termination of pregnancy, when it was no longer possible[99]. Similarly there could be no claim in delict because the doctor owed no duty to the child to give the child's mother an opportunity to terminate the pregnancy, and it was impossible to calculate damages, being the difference between an impaired life and no life.

6.2.8 Afrox Healthcare Bpk v Strydom[100]

Facts

The appellant was the owner of a private hospital. The respondent had been admitted to the hospital for an operation and post-operative medical treatment. Upon admission, an agreement was concluded between the parties. An indemnity clause formed part of the agreement. It read:

> "2.2 Ek onthef die hospitaal en/of sy werknemers en/of agente van alle aanspreeklikheid en ek vrywaar hulle hiermee teen enige eis wat ingestel word deur enige persoon (insluitende 'n afhanklike van die pasiënt) weens skade of verlies van watter aard ookal (insluitende gevolgskade of spesiale skade van enige aard) wat direk of indirek spruit uit enige besering (insluitende noodlottige besering) opgedoen deur of skade berokken aan die pasiënt of enige siekte (insluitende terminale siekte) opgedoen deur die pasiënt wat ook al die oorsaak/oorsake is, net met die uitsluiting van opsetlike versuim deur die hospitaal, werknemers of agente."

According to the respondent, it was a tacit term of this agreement that the appellant's nursing staff would treat him in a professional manner and with reasonable care. After the operation, certain negligent conduct by a nurse led to complications setting in, which caused the respondent to suffer damages. The respondent argued that the negligent conduct of the nurse had constituted a breach of contract by the appellant

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99 A person also cannot act as an agent for a non-existent principal. In *Commissioner For Inland Revenue v Friedman And Others NNO* 1993 (1) SA 353 (A) the court stated that: "It is common, for example, to speak of someone who is 'representing' a company yet to be formed, or of a curator who is 'representing' unborn heirs under a will. As a matter of law we know, of course, that it is impossible for someone to enter into a valid contract as agent for a non-existent person..."

100 *Afrox* 2002 (6) SA 21 (SCA)

and instituted an action holding appellant responsible for the damages suffered. The admission document signed by the respondent during his admission to the hospital contained an exemption clause, providing that the respondent 'absolved the hospital and/or its employees and/or agents from all and indemnified them from any claim instituted by any person (including a dependant of the patient) for damages or loss of whatever nature (including consequential damages or special damages of any nature) flowing directly or indirectly from any injury (including fatal injury) suffered by or damage caused to the patient or any illness (including terminal illness) contracted by the patient whatever the causes are, except only with the exclusion of intentional omission by the hospital, its employees or agents'. The appellant relied on such clause to avoid liability. The respondent advanced several reasons why the provisions of the exclusion clause could not operate against him. The respondent contended that the relevant clause was contrary to the public interest, that it was in conflict with the principles of good faith or bona fides and that the admission clerk had had a legal duty to draw his attention to the relevant clause, which he had not done. The grounds upon which the respondent based his reliance on the public interest were the alleged unequal bargaining positions of the parties at the conclusion of the contract, as well as the nature and ambit of the conduct of the hospital personnel for which liability on the part of the appellant was excluded and the fact that the appellant was the provider of medical services. The respondent alleged that, while it was the appellant's duty as a hospital to provide medical treatment in a professional and caring manner, the relevant clause went so far as to protect the appellant from even gross negligence on the part of its nursing staff. This was contrary to the public interest.

The respondent argued further that s 39(2) of the Constitution obliged every court, when developing the common law, to promote the spirit, purport and object of the Bill of Rights. The effect of s 39(2) was therefore that, in considering the question of whether a particular contractual term conflicted with the public interest, account had to be taken of the fundamental rights contained in the Constitution. It was argued that the relevant clause conflicted with the spirit, purport and object of s 27(1)(a) of the Constitution, which guaranteed each person's right to medical care, and as such was accordingly in conflict with the public interest.

As an alternative, the respondent argued that, even if the clause did not conflict with the public interest, it was still unenforceable as it was unreasonable, unfair and in conflict with the principle of *bona fides* or good faith. As a further alternative it was argued that the respondent had, when signing the admission document, been unaware of the provisions of the clause. The evidence was that the respondent had signed the document without reading it, even though he had had an opportunity to do so. The respondent contended that the admission clerk had had a legal duty to inform him of the content of the clause and that he had failed to do so. The respondent's reason for contending that such a legal duty existed was that he did not expect a provision such as the one contained in the relevant clause in an agreement with a hospital. The provincial division had found for the respondent.

Judgment

The court *a quo* took as its point of departure that the onus was on the appellant to show that the provisions of clause 2.2 were enforceable against the respondent. As authority for this position it cited *Durban's Water Wonderland (Pty) Ltd v Botha and Another*[101]. The Supreme Court of Appeal (SCA) in *Strydom* stated that this case was, however, authority for the complete opposite as appeared from the dictum of Scott JA at 991C-D[102]

The respondent argued that the grounds on which clause 2.2 was not enforceable against him were –

(a) The clause was contrary to the public interest;
(b) The clause was in conflict with the principles of good faith;
(c) The admissions clerk had a legal duty to draw his attention to clause 2.2 at the time of the conclusion of the contract and he failed to do so

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101 *Durban's Water Wonderland* 1999 (1) SA 982 (SCA).

102 Scott JA stated: "The respondents' claims were founded in delict. The appellant relied on a contract in terms of which liability for negligence was excluded. It accordingly bore the onus of establishing the terms of the contract. (The position would have been otherwise had the respondents sued in contract. See *Stocks & Stocks (Pty) Ltd v T J Daly & Sons (Pty) Ltd* 1979 (3) SA 754 (A) at 762E - 767C.)"

With regard to the public interest Brand JA stated that a contractual provision which is unfair on the basis that it is in conflict with the public interest is legally unenforceable and that this principle was accepted and applied in *Sasfin (Pty) Ltd v Beukes*[103] and *Botha (now Griessel) and Another v Finanscredit (Pty) Ltd*[104]. Brand JA quoted the dictum of Smalberger JA in the former where he stated:

"The power to declare contracts contrary to public policy should, however, be exercised sparingly and only in the clearest of cases, lest uncertainty as to the validity of contracts result from an arbitrary and indiscriminate use of the power. One must be careful not to conclude that a contract is contrary to public policy merely because its terms (or some of them) offend one's individual sense of propriety and fairness. In the words of Lord Atkin in Fender v St John-Mildmay 1938 AC 1 (HL) at 12: . . .
'the doctrine should only be invoked in clear cases in which the harm to the public is substantially incontestable, and does not depend upon the idiosyncratic inferences of a few judicial minds…'
In grappling with this often difficult problem it must be borne in mind that public policy generally favours the utmost freedom of contract, and requires that commercial transactions should not be unduly trammelled by restrictions on that freedom."

Brand JA pointed out that these cautionary words were emphasised more recently in *Brummer v Gorfil Brothers Investments (Pty) Ltd en Andere*[105]; *De Beer v Keyser and Others*[106]; *Brisley v Drotsky*[107]. He said that concerning exclusionary or indemnity clauses in South African law the position is that such clauses although valid and enforceable, must be restrictively interpreted.[108] He observes that these types of clauses have become the rule rather than the exception in standard contracts and that the limits of such clauses are apparently determined largely by business considerations such as savings in insurance premiums, competitiveness and the possibility of scaring off prospective clients. Brand JA stated that the fact that exclusionary clauses as a category are enforced does not mean that a specific exclusionary clause cannot be declares by the court as being contrary to the public interest and therefore unenforceable. The standard used with regard to exclusionary clauses does not differ from that applicable to other clauses which are alleged, due to

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103 *Sasfin* 1989 (1) SA 1 (A)
104 *Botha (now Griessel)* 1989 (3) SA 773 (A)
105 *Brummer* 1999 (3) SA 389 (SCA) at 420F
106 *De Beer* 2002 (1) SA 827 (SCA) op 837C - E
107 *Brisley* 2002 (4) SA (1)
108 *Government of the Republic of South Africa v Fibre Spinners & Weavers (Pty) Ltd* 1978 (2) SA 794 (A) at 804C - 806D and *Durban's Water Wonderland (Pty) Ltd v Botha and Another* (supra op 989G - I).)

considerations of public interest, to be unenforceable[109]. The three grounds upon which the respondent based his arguments concerning the public interest were:

(a) the uneven bargaining position between the parties with respect to the agreement;
(b) the nature and circumstances of the actions of the hospital staff against which the appellant is being indemnified;
(c) the fact that the appellant was the provider of medical services.

With regard to (a) above Brand JA stated that it was not obvious on the face of it that an inequality in bargaining power between the parties does not in itself justify a conclusion that a contractual provision which is to the advantage of the stronger party will be in conflict with the public interest. At the same, time, he said, it must be accepted that unequal bargaining power is indeed a factor which, together with other factors, can play a role in considerations of the public interest. Nevertheless the answer to the respondent's invocation of this factor in the present case, is that there is absolutely no evidence to show that the respondent during the conclusion of the contract was in a weaker bargaining position than that of the appellant.

Brand JA stated that the respondent's second ground of objection which has relevance to the potential scope of clause 2.2, links to some degree to his third ground. According to this ground the respondent's objection was that while the appellant's duty as a hospital is to provide medical treatment in a professional and careful manner, clause 2.2 goes so far as to indemnify the appellant against even the gross negligence of its nursing staff. The respondent submitted that this is in conflict with the public interest. The court said that although there is direct support to be found in Strauss, *Doctor, Patient and the Law*[110] for the view that the indemnification of a hospital against gross negligence of its nursing staff would be in conflict with the

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109 At p 35 of the judgement: "Die feit dat uitsluitingsklousules as 'n spesie in beginsel afgedwing word, beteken uiteraard nie dat 'n bepaalde uitsluitingsklousule nie deur die Hof as strydig met die openbare belang en derhalwe as onafdwingbaar verklaar kan word nie. Die bekendste voorbeeld van 'n geval waar dit wel gebeur het, is waarskynlik die beslissing in *Wells v South African Alumenite Company* 1927 AD 69 op 72 waarvolgens 'n kontraksbeding wat aanspreeklikheid vir bedrog uitsluit, as strydig met die openbare belang en derhalwe ongeldig verklaar is. Die maatstaf wat aangewend word met betrekking tot uitsluitingsklousules verskil egter nie van dié wat geld vir ander kontraksbedinge wat, na bewering, weens oorwegings van openbare belang ongeldig is nie. Die vraag is telkens of die handhawing van die betrokke uitsluitingsklousule of ander kontraksbeding, hetsy weens uiterste onbillikheid, hetsy weens ander beleidsoorwegings, met die belange van die gemeenskap strydig sal wees."

110 Strauss third edition at p305

public interest, it must be born in mind in the adjudication of the subjective ground of objection that the respondent did not in his pleadings rely upon gross negligence on the part of the appellant's nursing staff. He alleged nothing more than negligence. The question whether the contractual exclusion of a hospital's liability for damages caused by the gross negligence of its nursing staff would be contrary to the public interest, said Brand JA, was thus not the issue in the present case. Brand JA stated that even if one accepted the submission that it is indeed the case, this would not automatically invalidate clause 2.2. Apparently the provisions of the clause in this case would rather be interpreted so as to exclude gross negligence. Brand JA quoted the dictum of Innes CJ in *Wells v South African Alumenite Company* (*supra*) where he stated[111]:

"Hence contractual conditions by which one of the parties engages to verify all representations for himself, and not to rely upon them as inducing the contract, must be confined to honest mistake or honest representations. However wide the language, the Court will cut down and confine its operations within those limits."

Brand JA noted with respect to the third ground upon which the respondent relied that it was related to the fact that the appellant was a provider of medical ices. According to this ground it is generally impermissible for providers of medical services to add an exclusionary clause such as clause 2.2 to a standard contract. In this regard the respondent relied on section 27(1)(a) of the Constitution in terms of which everyone has a right to medical care. Brand JA stated that, as he understood the judgment of the court *a quo* this was the main ground upon which the decision in favour of the respondent was founded. He noted that the respondent did not rely on the fact that clause 2.2 directly violates the constitutional values which are entrenched in section 27(1)(a). Brand J held that even. accepting that section 27(1)(a) is horizontally applicable in terms of section 8(2) of the Constitution and therefore binding on a private hospital – which question did not pertinently arise for decision in this case – clause 2.2 does not prohibit the access of any person to medical care. Even from the point of view that section 27(1) binds a private hospital, this section does not apparently prevent private hospitals from asking for payment for medical services or imposing legally enforceable

111 *Wells* fn 109 *supra* at p72-73

Conditions on the provision of such services. The question said Brand J, still remains whether clause 2.2. is such a legally enforceable provision or not. According to the respondent's submission, the role of section 27(1)(a) is implied by the provisions of section 39(2) of the Constitution according to which each court is obliged in the development of the common law, to promote the spirit, purport and objects of the Bill of Rights. The effect of section 39(2), it was argued for the respondent, is that in the consideration of the question of whether a particular contractual provision is in conflict with the public interest, regard must be had to the fundamental rights which are set out in the Constitution. It was submitted with regard to the argument that clause 2.2 was enforceable prior to the Constitution, that it is now in conflict with the spirit, purport and object of section 2791)(a) and is consequently contrary to the public interest. Brand JA stated that seeing that the Constitution first came into effect on 04 February 1997 while the agreement between the parties arose on 15 August 1995, the first question in considering this argument is whether section 39(2) empowers and obliges the court to rely on constitutional provisions which were not in operation when the contractual relationship between the parties existed. Concerning direct breach, said Brand JA, the constitutional has no retrospective power. Transactions which were valid when it commenced are thus not rendered invalid retrospectively with regard to the direct application of the Constitution[112]. Brand JA noted that the question concerning the possible retrospective influence of the Constitution in an indirect manner as envisaged in section 39(2) had not yet been expressly decided. He noted that the fact that this is not a simple question is evident from *Ryland v Edros*[113] and *Amod v Multilateral Motor Vehicle Accidents Fund (Commission for Gender Equality Intervening)*[114]. Brand JA said he found it unnecessary to give attempt to provide a conclusive answer to this question. In the light of his opinion concerning the effect of section 27(1)(a) on the validity of clause 2.2, he was prepared to accept in favour of the respondent that the provisions of section 27(1)(a) should be taken into account although the relevant agreement was concluded on 15 August 1995 and there was also no matching provision in the interim Constitution. He noted that in *Carmichele v Minister of Safety and Security and*

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112 *Du Plessis and Others v De Klerk and Another* 1996 (3) SA 850 (CC) (1996 (5) BCLR 658) para [14]; *Gardener v Whitaker* 1996 (4) SA 337 (CC) (1996 (6) BCLR 775) para [13].)

113 *Ryland* 1997 (2) SA 690 (K) at 709G - 710C

114 *Amod* 1999 (4) SA 1319 (SCA) at 1329A - E para [22]

Another (Centre for Applied Legal Studies Intervening)[115] it was decided that, on the application of section 39(2) of the Constitution the determination of what comprises the convictions of the community for the purposes of the law of delict could not take place without taking into account the values to which the Constitution subscribes. Brand JA stated that he had no doubt that the same principle also applied to a consideration of whether a particular contractual provision was contrary to the public interest. In this regard he quoted the dictum of Cameron JA *Brisley v Drotsky* (*supra*)[116]. On the application, said Brand JA, of this principle the only constitutional value upon which the respondent relies is that contained in section 27(1)(a). This leads immediately to the question: why is clause 2.2 in conflict with section 27(1)(a)? He observed that it was indeed correctly conceded by the respondent that clause 2.2 does not stand in the way of the provision of medical services to anyone and that a hospital's reliance on legally acceptable conditions for the provision of medical services is also not in conflict with section 27(1)(a). The respondent's answer to the question posed was based on the point of departure while that the constitutional value embodied in section 27(1)(a) does not envisage the mere provision of medical services but includes the provision of such services in a professional and careful – in other words non negligent – manner, clause 2.2 is in conflict with the values embodied in section 27(1)(a) and is thus in conflict with the public interest. The answer to this argument, said Brand JA, is that it is constructed entirely upon a *non sequitur*. Firstly, the appellant's nursing personnel are already bound by their professional code and they are already subject to the statutory authority of their professional body. Secondly, negligent acts by the appellant's nursing staff would not be in the interests of the appellant's reputation and competitiveness as a private hospital. Thirdly, the respondent's argument comes down in effect to that fact that the appellant's nursing staff due to the existence of clause 2.2 will be purposefully (or otherwise intentionally) negligent – something which by definition amounts to self contradiction. The court pointed out that article 27(1)(a) was not the only constitutional value which was relevant to the present case. It quoted again from Cameron JA in *Brisley v Drotsky* (*supra*) where it was stated:

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115 *Carmichele* 2001 (4) SA 938 (CC) at para [35]

116 *Brisley* fn 107 *supra*. According to Cameron JA, "Public policy . . . nullifies agreements offensive in themselves - a doctrine of considerable antiquity. In its modern guise "public policy" is now rooted in our Constitution and the fundamental values it enshrines."

"(T)he constitutional values of dignity and equality and freedom require that the Courts approach their task of striking down contracts or declining to enforce them with perceptive restraint . . . contractual autonomy is part of freedom. Shorn of its obscene excesses, contractual autonomy informs also the constitutional value of dignity."

Brand JA stated that the constitutional nature of contractual freedom embraces in its turn the principle *pacta sunt servanda*. He noted that this principle was expressed by Steyn CJ in *SA Sentrale Ko-op Graanmaatskappy Bpk v Shifren en Andere*[117] as follows:

"die elementêre en grondliggende algemene beginsel dat kontrakte wat vryelik en in alle erns deur bevoegde partye aangegaan is, in die openbare belang afgedwing word".

In the light of these considerations, said Brand JA, the respondent's position that a contractual provision in terms of which a hospital is indemnified against the negligent actions of its nursing staff is in principle contrary to the public interest cannot be accepted. Brandt JA noted the statement of the court *a quo* that -

"Section 39 of the Constitution implicitly enjoins every court to develop common law or customary law. In my mind the tendency of lower courts blindly following the path chartered many years ago until altered by the higher Court (stare decisis) is not consonant with the provisions of section 39 of the Constitution"

and said that if the trial court intended by this that the principles of *stare decisis* as a general rule are not to be used in the application of section 39(2) this was, at least concerning post-constitutional decisions, clearly wrong. He referred to the dicta of Kriegler J in *Ex parte Minister of Safety and Security and Others, In re S v Walters and Another*[118] where stated:

"(T)he Constitution enjoins all courts to interpret legislation and to develop the common law in accordance with the spirit, purport and objects of the Bill of Rights. In doing so, courts are bound to accept the authority and the binding force of applicable decisions of higher tribunals"

and in para [61]

"High Courts are obliged to follow legal interpretations of the SCA, whether they relate to constitutional issues or to other issues, and remain so obliged unless and until the SCA itself decides otherwise or this Court does so in respect of a constitutional issue. It should be made plain, however, that this part of the judgment does not deal with the binding effect of decisions of higher tribunals given before the constitutional era."

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117 *Shifren* 1964 (4) SA 760 (A)

118 *In re S v Walters* 2002 (4) SA 613 (CC)

Brand JA stated that concerning preconstitutional decisions of the SCA with regard to the common law, in his view a distinction should be drawn between three situations that exist in the constitutional context:

1. The situation in which the High Court is convinced that the relevant rule of the common law is in conflict with the constitutional provision. In this instance the High Court is obliged to depart from the common law. The fact that the relevant rule of the common law was laid down pre-constitutionally by the SCA makes no difference. The Constitution is the supreme law and where a rule of common law is in conflict with it, the latter must give way.

2. The situation in which the pre-constitutional decision of the SCA was based on considerations such as boni mores or public interest. If the High Court is of the opinion that such decision, with regard to constitutional values, no longer reflects that boni mores or considerations of public interest, then the High Court is obliged to depart therefrom. Such a departure said Brand JA is not in conflict with stare decisis because in any event it is accepted that the boni mores and considerations of public interest do not remain static.

3. A situation in which a rule of common law which was laid down in a pre constitutional decision of the SCA, is not directly in conflict with any specific provision of the Constitution and is also not dependent on changing considerations such as boni mores or public interest. Nevertheless the High Court is convinced that the relevant rule, upon the application of section 39(2), should be changed in order to promote the spirit, purport and objects of the Constitution. Is the High Court in such a situation empowered to give effect to its convictions or is it still obliged to apply the common law as it was preconstitutionally in terms of the principles of stare decisis? The answer, said Brand JA is that the principles of stare decisis still apply and that the High Court is not empowered by section 39(2) to depart from the decisions of the SCA whether they are pre- or post- constitutional. He noted that section 39(2) of the Constitution must be read in conjunction with section 173. According to the latter recognition is given to the inherent competence of the High Court –

> together with the SCA and the constitutional court – to develop the common law. In exercising this inherent competence, said Brand JA, the provisions of section 39(2) are of relevance. Before the Constitution, said Brand JA, the High Court just like the SCA, had the inherent competence to develop the common law. This inherent competence was, however, dependent upon the rules which found expression in the doctrine of stare decisis. In the opinion of Brand JA, this rule was neither expressly nor impliedly set aside by the Constitution. Section 39(2), he said, contains the underlying implication that the relevant court has the power to amend the common law. The question of whether the relevant court has that capacity is determined by inter alia the *stare decisis* rule. Brand J pointed out that the provisions of the Constitution are not just a set of rules but an entire value system. Brand JA observed that there is sometimes mutual tension between the values of the system which can only be resolved by careful consideration and reconciliation. In implementing this value system, individual judges will differ from each other. In such circumstances the granting to every judge of the capacity on the grounds of his individual perspective in accordance with the application of this value system the power to deviate from the decisions of the SCA would necessarily lead to a lack of uniformity and certainty.

On the subject of good faith as an alternative basis of the respondent's case, Brand JA observed that this principle finds its origin in a minority judgement by Olivier JA in *Eerste Nasionale Bank van Suidelike Afrika Bpk v Saayman NO*[119]. He observed that the SCA in its majority decision in *Brisley v Drotsky* (*supra*) put the judgement of Olivier JA in perspective. With regard to the place and role of abstract ideas such as good faith, reasonableness, fairness and justice, the majority of the court in Brisley held that although these considerations underlie the South African law of contract, this does not make them an independent, or 'free-floating', foundation for the setting aside of contractual provisions. Put differently, said Brand JA, these abstract considerations represent the foundation and raison d'être for the present legal rules and can also lead to the formulation and alteration of rules of law but that are not themselves rules of law. When it comes to the enforcement of contractual provisions, the court has no discretion and does not deal in abstract ideas but rather on the basis

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119 *Saayman* 1997 (4) SA 302 (SCA) at 318

of crystallised and established rules of law. Thus, said Brand JA, the alternative basis upon which the respondent relies is in reality not an independent basis for his case.

With regard to misrepresentation and mistake Brand JA stated that consideration of this alternative required that the factual background be set out in more detail. He noted that the respondent's evidence was that he signed the admission document without reading it in the place indicated with a cross. The respondent's attention was not drawn to clause 2.2. In the absence of any evidence to the contrary it must be accepted, said the court, that the respondent was not aware of the contents of clause 2.2 when he entered into the agreement. Nonetheless the respondent conceded that he knew that the admission document contained the terms of the contract between himself and the appellant and he did not dispute that he had full opportunity to read the document. In these circumstances the fact that the respondent signed the document without reading it does not lead, as a rule to the result that he is not bound by its contents. Brand JA then referred to the case of *Burger v Central South African Railways*[120] in which it was held that a person who signs an agreement without reading it does so at his own risk and is consequently bound thereby as though he were aware of its provisions and expressly consented thereto[121]. Brand JA conceded that there were certain exceptions to this general rule and referred in this regard to Christie[122]. The exception relied upon by the respondent was that the admissions clerk had a duty to inform him of the contents of clause 2.2 and that he failed to do so. The respondent conceded that as a general principles there is no legal duty upon a contracting party to inform the other of the contents of their agreement. The reason why the respondent alleged that such a duty existed on the admissions clerk was that he, the respondent, did not expect such a clause in an agreement with a hospital. Seeing that a hospital is supposed to supply medical and professional services in a professional manner, the respondent argued that he did not expect that the applicant would try to indemnify itself against the negligence of its own nursing personnel. The answer to this, said Brand JA, is that the respondent's subjective expectations concerning the contract between himself and the appellant play no role in the question of whether there was a duty on the admissions clerk to point out clause 2.2. to him. What is of relevance to

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120 *Burger* 1903 TS 571

121 Brand JA also referred to *George v Fairmead (Pty) Ltd* 1958 (2) SA 465 (A)

122 Christie RH *The Law of Contract* 4th edition at p 202

this question said Brand JA, is whether a provision such as clause 2.2 could reasonably be expected or, if it was objectively speaking, unexpected. He stated that indemnity clauses such as clause 2.2 are presently the rule rather than the exception in standard contracts these days. Notwithstanding the respondent's submission to the contrary, the court said that it could see no reason in principle to distinguish between private hospitals and suppliers of other services. Thus it cannot be said that a provision such as clause 2.2 was, objectively speaking unexpected. There was thus no duty, said Brand JA, upon the admissions clerk to bring the clause to the attention of the respondent. Therefore the respondent was bound to the terms of the clause as if he had read it and expressly agreed to it. The court concluded that the appeal must succeed with costs and that the decision of the court a quo should be reversed.

Discussion

It is submitted, with respect, that the decision of the Supreme Court of Appeal in this case is both unfortunate and regrettable for the reasons set out below - not least of which is the fact that the court saw fit not to distinguish between suppliers of health care services and any other kind of supplier. The most obvious way to demonstrate the problems with this decision is to apply it within the public sector. On this basis of this decision would and should an exclusion clause of the nature used by Afrox Healthcare be applicable by government hospitals in respect of the people to whom they deliver health care services? If suppliers of health care services are the same as any other, then the government, as a supplier of health care services, should be able to include such a clause in its admission documentation. The fact that patients, as non-lawyers, may not understand the nature or import of such a clause, clearly does not make a difference to the Supreme Court of Appeal. The fact that health care 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 is submitted, it should have been used to strike it down. 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 services of a registered professional because if they did not, they might as well go to Joe Public for those same services. What

would be the reason for seeking out professional help if it meant that the professional in question was not bound to follow certain ethical rules and standards of practice associated with his profession? The Medical Protection Society has different rates for different types of indemnity cover depending on whether a health professional is self employed or employed by a third party. The rates for the latter are much lower on the assumption that the employer either self insures (in the case of the state) or takes out some form of public liability insurance[123]. If a nurse's professional indemnity cover

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123 In fact some years ago Dr John Hickey of the Medical Protection Society and actuary Tony Mason wrote a paper entitled 'Funding of Clinical Negligence Liabilities in the Public Sector' (obtained from Dr John Hickey, Medical Protection Society 33 Cavendish Square, London WIG 0PS, UK) in they argue why doctors in public sector employment should not be required to purchase professional indemnity protection. Insurance in the public sector is particularly problematic due to the fact that government self insures. A number of provincial governments in South Africa were considering legislation to compel publicly employed doctors to purchase professional indemnity cover against claims of clinical negligence. The current position is that other than in cases of gross negligence, the hospital will assume vicarious liability for the acts or omissions of its employees and will indemnify those employees against such claims. The paper was prepared at the request of the South African Medical Association and sets out to show that by implementing such a change the costs to the public purse of clinical negligence would be greater than is currently the case. It further seeks to show that there is also a significant risk that the cost of professional indemnity protection for individuals employed in the public sector will be prohibitive, particularly for high risk specialities and is likely to reduce the recruitment of those specialities. In fact, it is submitted, the same arguments are applicable to professionals in the private sector although in the case of medical practitioners, these are generally self-employed. The authors stated that medical negligence probably has one of the longest 'tails' of all types of insurance (another contextual difference of which Brand JA was clearly unaware) and most insurance companies refuse to underwrite this type of business or will only offer the more limited claims made coverage. The 'tail' refers to the delays that occur between the occurrence of an adverse incident (that will probably give rise to a claim) and the time it is first reported and the further delay until that claim is eventually settled. The average delay between incident and settlement may be as long as 6 or 7 years and increases for the larger more complex claims which, in some cases, take decades. When it is appreciated that the rate of claims inflation (particularly in the cost of settling large claims) may be 1-2% higher than earnings inflation, it is perhaps not surprising that so few insurers are interested in this business and that the cost to purchasing cover is so high. Apart from claims inflation, the other noticeable trend over the last 15 years has been the steep increase in the number of claims and it is clear that the general public has become more consumerist and litigious. Because of the average delay of several years between an incident and the time it is reported as a claim, the underlying claims frequency can often be masked so that the experience appears more favourable than it actually is. The authors point out that there are many disadvantages to compelling publicly employed staff to purchase their own indemnity protection and these have been recognised in recent years by governments around the world. State indemnity schemes are now in place in England, Wales, Scotland, Australia, Malaysia, Hong Kong and in many European and American States. The reasons they give are:
Cost of cover: This can be substantial, particularly for high-risk specialities such as obstetrics, gynaecology, orthopaedic surgery, neurosurgery and plastic surgery. The authors give the example of a submission by the MPS to the Irish Department of Health in which it was reflected that specialist obstetricians in Ireland comprised 5% of MPS membership, contributed 9% of income and were responsible for 20% if reported claims by number and 33.3% of liabilities. They state that similar rations are likely to exist in South Africa. Claims experience in South Africa is deteriorating i.e. increasing although not as dramatically as elsewhere in the world. Therefore in all likelihood rates will rise year on year.
Demands by staff for reimbursement of subscriptions: Staff tend to demand reimbursement from the employers for subscriptions. Reimbursement, say the authors, means that effectively the public hospitals move from a pay as you go basis (as is currently the case) to claims made or occurrence based funding, diverting public funds from the provision of care to the indemnifying company.
Affordability in certain specialities: If there is no reimbursement of subscriptions, then the paradox occurs that doctors in different specialities who are paid the same will have to pay significantly different subscription rates, leading to demands for differing salary levels for different specialities. For junior staff in the very high-risk specialities their subscription rates may be higher than their salaries.
Adverse effect on recruitment into specialities: If the cost of protection so very much higher in certain specialities and there is no reimbursement, it will be increasingly difficult to recruit those specialities.
Risk of no cover and complexity: If staff choose to purchase cover on a claims made basis, there is a very real risk of gaps in cover if they change indemnifiers or choose for any reason not to purchase run off cover when the leave the hospital's employ. This leads to exposure of the hospital to clinical negligence liability and the possibility of uncompensated patients.
Administration and claims management costs: In the experience of the MPS claims arise from a sequence of systems failures or errors some of which are the responsibility of the employing hospitals rather than the individual staff member, for example equipment failures. In circumstances such as these the hospital feels compelled to instruct its own lawyers leading to arguments over apportionment of responsibility. The increased expenditure on legal fees is one of the reasons cited by the Irish government for introducing a State indemnity scheme.
It is submitted that for present purposes there is likely to be no difference between the public and private health sectors in South Africa with regard to nurses since in both sectors they tend to be employees rather than self-employed.

takes into account the vicarious liability of her employer and is lower than would have been the case had she been self-employed, then this judgment of the Supreme Court of Appeal may effectively have left patients who are the victims of negligence of nurses without recourse to compensation. A disciplinary hearing by a professional council even assuming any sanction is imposed, is cold comfort to a patient that has lost the ability to work or to function in society or that has experienced considerable pain and suffering and become liable for extra medical expenses as a result of professional negligence. It is submitted with respect that the confidence of the Supreme Court of Appeal that the existence of professional bodies to discipline professionals who do not practise their professions according to acceptable standards is a sufficient deterrent of professional negligence and adequately reduces the attendant risks to patients is naïve to say the least. It is tantamount to saying that the criminal law sufficiently addresses the risks of crime for the man in the street and that one should not expect, or take measures to protect oneself against, criminal behaviour because a system exists for the prosecution of crime. The court as long ago as 1957 refused to accept the view that the delicts of health professionals who are employed by a hospital should not attract vicarious liability for their employer[124]. It is not being

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Furthermore on the salaries paid to nurses, relative to those received by medical practitioners, it is quite likely that nurses would not be able to afford professional indemnity cover at all on the basis of the arguments above.

124 See *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T) and *Dube v Administrator, Transvaal* fn 78 *supra*. See also the discussion of this subject in *Mtetwa v Minister of Health* 1989 (3) SA 600 (D) and the discussion there of *Lower Umfolosi District War Memorial Hospital v Lowe* 1937 NPD 31 and *St Augustine's Hospital (Pty) Ltd v Le Breton* 1975 (2) SA 530 (D). In *Mtetwa* the court expressly refused to follow the approach of Feetham J in *Lower Umfolosi* that: "I accept the proposition that in the performance of their professional duties nurses are not under the control of the hospital authority so as to become its servants, and that the obligation of the hospital authority in regard to the professional work of its nurses is limited to taking reasonable care to assure itself of the professional competence of the nurses whom it employs. No question as to the competence of the nurses employed arises in this case, because there is an admission on the record to the following effect: 'Mr Lowe, attorney for plaintiff, admits that there was no negligence on the part of the Board in the appointment of the nurses, and that he is satisfied that the nurses are all duly qualified.'"
And again, at p 42: 'Now I differ from the conclusion at which he arrives. It seems to me that, on his own showing, it is perfectly clear that the placing of this hot bottle in the patient's bed, and the subsequent supervision of the patient while recovering from the anaesthetic with the hot water bottle in his bed, were professional duties on the part of the nurse or nurses concerned. It is irrelevant to say that, when the patient is in a normal condition and not disabled, he can place the hot water bottle where he likes. The dominating fact in regard to this case is that the patient was recovering from an anaesthetic after an operation. For that purpose he required a hot water bottle in his bed in order to provide conditions necessary for his proper recovery. He was not in a condition to protect himself from the hot water bottle, or to judge the heat of the hot water bottle; he was entirely in the hands of the nurse or nurses, and they were in charge of him, not as domestic servants, but as nurses responsible for seeing that proper conditions were provided in which he could recover from the effects of the anaesthetic; and in regard to the whole of this business in connection with the placing of the bottle in the bed, the heating of the bottle, the wrapping of the bottle and the supervision of the patient, they were bound to use their professional skill; their professional training taught them that it was necessary for the patient to have a hot water bottle, that he was incapable of protecting himself from the bottle, and that, owing to possible movements on the part of the patient in the condition in which he was, supervision was necessary. They were acting, therefore, in a professional manner and not as domestic servants insofar as they dealt with the hot water bottle, and, that being so, they failed in the carrying out of professional duties for the discharge of which the hospital authority was not responsible.'
Nienaber J noted in *Mtetwa* that because *Lower Umfolosi* was a judgment of two Judges, Fannin J, in a later Natal case, *St Augustine's Hospital (Pty) Ltd v Le Breton* 1975 (2) SA 530 (D), regarded himself as bound by it, notwithstanding some strong misgivings he expressed about its correctness. That case also involved negligence on the part of the nursing staff. A 92-year-old patient fractured her leg when, in the middle of the night, she fell out of a hospital cot. The Court stated, apropos of the earlier judgment and the English cases cited in it, at 536H - 537A: 'The effect of these cases is to render liable a hospital authority for the negligence of doctors, surgeons and nurses, employed by them on a full- or part-time basis, in the performance of the professional duties they are employed to perform. The later view now adopted in

argued here that the court in *Afrox* was even suggesting that a hospital employer cannot be held vicariously liable for the delicts of its employees. The point being made is rather that the statement of Brand AJ to the effect that the entire argument that clause 2.2 would promote negligent and unprofessional conduct on the part of the nursing staff is built on a *non sequitur*, firstly because the nursing staff are still bound to observe their professional code of conduct and secondly because action against an employee of the applicant for negligent acts would adversely impact on its reputation and competitiveness, does not take into account the practical realities of the situation. Real life, it is submitted, is far more complicated than this. Brand JA has seized only upon those factual elements within a larger factual matrix, which suit his particular viewpoint irrespective of how they impact in reality upon the other elements of the matrix to produce a result which Brand JA could not anticipate without more in-depth knowledge of the business of health service delivery than he apparently has[125]. The

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England seems to me to be the more correct one, and McKerron *The Law of Delict* 7th ed at 92, expresses the view that "'there can be no doubt as to the correctness of these decisions'".
It seems probable that, had this Court in 1937 had before it the 1942 and later English decisions, the result of the Lower Umfolosi case might well have gone the other way.'
And again, at 537H - 538:'That being so, I must apply the law as stated in the *Lower Umfolosi* case and hold that as in that case, so in the present case, in the absence of any special term in the contract between the hospital and the patient, the ordinary contract between patient and hospital does not cast upon the hospital an obligation to do more than take reasonable steps to assure itself of the professional competence of the nurses it employs to attend to the patient.'
And, finally, at 538D: 'I think I should add that, had I been free to do so, I would have been disposed to accept as more in accordance with our law the later English decisions, and to have applied the law as there applied and as applied in *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T), and *Dube v Administrator, Transvaal* 1963 (4) SA 260 (T), in neither of which, incidentally, do I find any reference to the *Lower Umfolosi* case.'
Nienaber J observed that the two Transvaal cases, as well as *Buls and Another v Tsatsarolakis* 1976 (2) SA 891 (T), neither mention nor support the distinction, which is pivotal to the decision in the Lower Umfolosi case, between professional work over which the hospital is said to have no control and for which it is accordingly not liable, and managerial or administrative duties performed by an employee, for which it is responsible. In the Transvaal cases the issue was simply whether the particular member of staff was negligent in the exercise of his duties, regardless of whether he was part of a professional team or not. As long as the decision in the Lower Umfolosi case stands, that is not, however, the prevailing view in Natal. It was that consideration that prompted the defendant's exception.
Nienaber J found in Mtetwa that: "The point on which the decisions in the *Lower Umfolosi* case hinged was that a member of the professional staff of a hospital was not a servant proper for whose misdeeds the hospital was accordingly responsible. At the time that was perceived to be a principle of law. Nowadays, I venture to suggest, the question is purely one of fact. The degree of supervision and control which is exercised by the person in authority over him is no longer regarded as the sole criterion to determine whether someone is a servant or something else. The deciding factor is the intention of the parties to the contract, which is to be gathered from a variety of facts and factors. Control is merely one of the indicia to determine whether or not a person is a servant or an independent worker." He held that: "To the extent that the judgment in the *Lower Umfolosi* case purported to enunciate a universal principle of law, namely that a hospital assumes no responsibility for the negligence of any member of its staff engaged in professional work, it has thus been overtaken by more recent authority, not only by the South African cases referred to but indeed by English ones as well. (See, for instance: *Gold v Essex County Council* [1942] 2 KB 293; *Collins v Hertfordshire County Council* [1947] KB 598; *Cassidy v Ministry of Health* [1951] 2 KB 343 (CA); *Roe v Minister of Health* [1954] 2 QB 66.) Professor J C van der Walt suggests (1976 THRHR 399 at 405) that the later English cases have undermined the foundation on which the judgment in the *Lower Umfolosi* case was based. I agree. The *ratio decidendi* of that judgment, in my respectful view, is outmoded and accordingly no longer authoritative."

125 In a sense, Brand JA's assumption that providers of health care services are no different from any other supplier is the central pillar of error in his judgment because it closes off to his mind the possibility that the delivery of health care services has its own unique angles which should be taken into account when deciding cases such as Afrox. It is submitted that the days when general legal principles could be successfully applied across vast expanses of different practical contexts are largely gone. In the practice and development of law these days, cognisance of context is critical if law is to remain rational and consistent within the larger legal system and relevant to society. In the context of information technology, for instance, the public policy principles around privacy and confidentiality of information as opposed to accessibility of information have been brought into focus in ways our forefathers would not have dreamt possible. Similarly in the context of the media in these days of satellite based communications and other high-speed telecommunication systems, the law has to take into account the value of such systems to businesses at both global and

local levels. They have changed the way that business transactions take place and the thinking of judges and other practical lawyers must keep pace with the implications of these developments in order to ensure that legal principles remain relevant. In the health care field there are similar technological developments and advances which require a willingness to understand the legal issues within a particular context rather than approach which holds that a contract is a contract is a contract no matter what the services it contemplates. However technology is only one consideration. There are others such as the existence of intervening third parties – in the health care context examples would be medical schemes, medical scheme administrators, brokers, managed care service providers, independent practitioners associations, and other provider networks - systemic imbalances between supplier and purchaser that are knowledge based and context driven, trade practices within a particular industry, accepted methods of doing business, the dictates of the particular product or service itself – examples in the health care environment would be sterilisation of equipment, adequate storage conditions for dangerous substances, the importance of uninterrupted power supplies the levels of skill and length of training required to perform certain procedures etc.

In the context of the present discussion it is significant to note that in 1996 Rob Knowles, the Australian Minister for Health, stated the terms of reference for an inquiry into the liability of the State of Victoria and Health Service Providers of the Law Reform Committee as follows:

1. The Government is concerned that the increasing cost of professional indemnity insurance could affect access to medical services.
2. The Parliamentary Law Reform Committee is requested to investigate options with respect to the following—
3. the need to ensure medical services provided are of a high standard and that where standards are not maintained people have suitable redress;
4. the reduction of any disincentives to the provision of health services by fears of inappropriate liability; the use of structured settlements to maximise the benefit to an injured person of any financial compensation ordered by a court; and alternatives to the current system of court-based compensation for people injured in the use of health services.

Dated 12 June 1996 *Victoria Government Gazette*, G 24, 20 June 1996, pages 1568 & 1569

The extent of the complexities of professional indemnity cover in the health care context is touched upon in the introduction to the report of the Law Reform Committee which reads as follows: "In September 1995, the Law Reform Committee was given a reference by the Governor-in-Council to inquire into, consider and report to the Parliament on issues arising out of court-based compensation for people who have suffered injuries as a result of services provided by a health service provider. The terms of reference for the Inquiry were amended in November, 1995. Four specific issues were identified as matters to which the Committee should direct its attention: the need to ensure that medical services provided are of a high standard and that where standards are not maintained people have suitable redress; the reduction of any disincentives to the provision of health services by fears of inappropriate liability; the use of structured settlements to maximise the benefit to an injured person of any financial compensation ordered by a court; and alternatives to the current system of court-based compensation for people injured in the use of health services. Following receipt of the reference, the Committee heard oral evidence from a number of individuals and considered some written submissions prior to undertaking research for the preparation of its Issues Paper No. 1 which was published in January 1996. Over thirty submissions were received prior to the initial closing date for receipt of submissions on the 18 March 1996. On 5 March 1996 the Parliament was dissolved for the state election and the Committee's reference lapsed. Following the election a new Committee was appointed on 14 May 1996 consisting of two former members and seven new members, including a new Chairman. Terms of reference for the current inquiry were published in the *Victoria Government Gazette* on 20 June 1996. They were in identical form to those as amended in November 1995. The Law Reform Committee is a joint investigatory Committee of the Victorian Parliament with a statutory power to conduct investigations into matters concerned with legal, constitutional and parliamentary reform or the administration of justice. The issues embodied in the terms of reference are extremely wide in scope and raise fundamental questions as to the role which court-based compensation should play in ensuring that people who suffer injuries through medical misadventure are adequately and properly compensated. A number of other inquiries have considered and are considering similar issues. The most recent of these are the Commonwealth Department of Human Services and Health's Professional Indemnity Review and the New South Wales Departments of Health and the Attorney-General, Joint Working Party on Medical Liability. The Victorian reference arose out of a number of specific concerns which were identified concerning the manner in which people receive compensation for medical misadventure in Victoria. First, was the widespread perception that the amounts of money paid by health service providers to obtain professional indemnity cover had increased to such an extent for practitioners in some specialities, such as obstetrics and gynaecology, that practice in these specialities is becoming financially unviable. The situation of rural general practitioners who undertake obstetric services infrequently was cited as the area of major concern. Secondly, extremely large awards of damages which have occasionally reached over five million dollars, were said to have exceeded the maximum amount payable by the mutual funds in respect of professional indemnity cover, thus leaving health service providers at risk of personal liability and those who have suffered injuries at risk of going uncompensated. Thirdly, concern had been expressed that the basis upon which liability in negligence was determined by courts in Australia was inappropriate in situations where an adverse outcome is an expected, if unfortunate and rare, consequence of a procedure carried out in good faith and in a professional manner. The situation which arises in cervical screening is given as an example of this. Fourthly, there is the problem of defensive medicine; namely, that doctors may be providing services in such a way as to ensure that the risk of professional liability is minimised, even if this entails the provision of services which may not be clinically necessary for patient care. Finally, there is a view that it is inappropriate for a health user injured through medical misadventure to receive a substantial award of damages on the basis of an estimated life expectancy, where the individual in question may die earlier than expected, thus providing his or her estate with a financial windfall. Similarly, it was considered to be unfair for individuals to be required to shoulder the financial burden of caring for a person injured through medical misadventure where their circumstances have altered from those predicted to occur at the time damages were assessed. The issues raised during this inquiry are particularly important given the findings of a recent study into the incidence of adverse events (that is, unexpected injuries) arising out of the use of health services in Victorian hospitals. The study which was publicly released on the day before the Committee adopted its report, found

judgment almost gives the impression that nurses and other professional staff employed by a private hospital operate fairly independently, almost as contractors, of their employer and that the hospital itself has no authority to supervise them nor does it have any responsibility to control them in the same way that other employers control their employees. The impression is created that the fact that these employees are professionals and therefore subject to the disciplinary powers of their professional body somehow reduces the weight of the public policy considerations that the employer should be held vicariously liable. The employer should be permitted to reduce its insurance burden by shifting the risk onto the professional in question – an individual employee. From a professional indemnity cover perspective this idea has been rejected by many different countries around the world[126].

With regard to the former argument, it is submitted that the frequency with which nurses are disciplined by the South African nursing council and even the relatively lower frequency with which they are found guilty and struck off the roll or their names removed from the register, is such that it gives the lie to this argument. Furthermore, an employer who is not vicariously liable for the negligence of its employees may be less concerned about taking preventive action to preclude professional negligence - even if it takes action to discipline the nurse as an employee after the event. Once a nurse is subject to a disciplinary proceeding by her professional body it is too late. The negligent act has already harmed a patient. Given the nature of the services rendered by nurses, such harm can include death and permanent disablement. As to the latter argument, when the nursing council disciplines a nurse and removes his or her name from the roll the name of his or her employer is not mentioned when the relevant notice is published in the Government Gazette[127]. It is submitted that this argument, whilst it may have some attraction in the

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that 62,949 patients experienced adverse events.[9] This represents a five percent error rate. The total number of adverse events was 67,260.[11] Most of these events consisted of complications arising out of surgical or medical procedures. Additionally, the study revealed that the death rate for persons experiencing an adverse event was 0.14 percent. Ross Wilson, the Director of Quality Assurance at the Royal North Shore Hospital in Sydney, described the rate of adverse events identified by the Victorian study as being 'of sufficient magnitude to demand action'. The Committee notes this is consistent with the findings of a study conducted in 19902.In light of this recent study, the Committee believes that the recommendations in this report will be significant not only to those who suffer an adverse outcome while using health services, and to health service providers, but also to the general community."
http://www.parliament.vic.gov.au/lawreform/hea/list.html

126 Hickey J and Mason A 'Funding of Clinical Liabilities in the Public Sector' fn 123 *supra*

127 The format of the notices is: "Notice is hereby given that in terms of section 29(1)(c) of the Nursing Act, 1978 (Act No 50of 1978), the name of [name of professional] has been removed from the register of registered nurses and midwives following on a disciplinary inquiry by the South African Interim Nursing Council into her conduct on [date]" The most recent notices found by the writer in the Government Gazette were placed by the South African Interim Nursing Council

abstract, does not reflect reality or the way in which disciplinary procedures and sanctions are in fact publicised. It is argued that even if the name of the employer had to be published in such a notice, the notices are usually issued singly, i.e. in respect of one nurse at a time.[128] It would take a very diligent lawyer indeed, let alone a layperson, to search through the Government Gazettes to identify a trend in terms of which the nurses employed at one particular hospital are found being guilty of negligence more frequently than at any other hospital. Given that not every court decision is reported and that not many cases of this nature get to court to begin with, not least due to the high cost of litigation in South Africa, such a trend is unlikely to become public knowledge through even the law reports. Consequently, it is submitted with respect, that the argument of the Supreme Court of Appeal that there is adequate protection for the patient against the risks of professional negligence of the applicant's employees because the applicant had a reputation and a competitive edge to maintain is based on a fallacy. Health services such as those provided by hospitals, are not in quite the same category as other services when it comes to word of mouth either. Most people do not regularly 'shop' at hospitals. They might be able to relate a good or bad experience whilst hospitalised at some stage of their lives but such anecdotal evidence is seldom if ever more influential upon a prospective patient than the advice of a medical specialist to the effect that they are seriously ill and must admitted to the hospital at which he practices even assuming that it relates to the same hospital to which the patient must be admitted. It may be that in some wards acceptable standards of nursing care are offered while in other wards in the same hospital, the same does not hold true simply due to the manner in which the particular ward in question is run by the person in charge. It is submitted that the court failed to take into account the fact that Afrox Healthcare as a publicly listed company is highly likely to be engaged in costly marketing campaigns in terms of which it trades on the levels of

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on the authority of the previous Acting Registrar in Gazette No 16949 dated 02 February 1996 Board Notice No 9 of 1996 dated 11 January 1996; Gazette No 17517 dated 01 November 1996 Board Notice 103 of 1996; Gazette No 17797 dated 21 02 1997 Board Notice 18 of 1997 dated 7 February 1997; Gazette No 17823 dated 07 March 1997 Board Notice No 23 of 1997 dated 24 February 1997. The Nursing Council has not published any such notices in the last few years and when enquiry was made to the Registrar of the Nursing Council as to the reason for this, it would seem that it simply has not been done by the relevant administrative unit within the South African Nursing Council. The Registrar did say that a public register was planned for the Council's website but it is not clear when such a facility will be made available. The Council in any event does not usually remove the names of more than 3 professionals from the register each year following upon disciplinary proceedings which could be an indication that the council is not itself effectively and efficiently dealing with recalcitrant professionals. There has been public complaint about the efficacy of most of the health professional councils in South Africa and the Department of Health is in the process of substantially amending the relevant legislation to deal with some of these problems. A Forum has also been created in terms of the National Health Act to act as ombudsman and to call the professional councils publicly to account for their performance of their functions.

128 The notices referred to in the footnote immediately *supra* are each in respect of only one nurse.

professionalism of its staff when touting for business[129]. This kind of information is very much publicly available. The company even boasts about its college of nursing[130]. It is submitted that the publication of this kind of information by private

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129 Presently on the website (http://www.afroxhealth.co.za/)is a document entitled "Core Values". It reads:
Core values
Organisational values are principles or qualities considered worthwhile by an organisation. At Afrox Healthcare there is a fundamental commitment to these values throughout the entire organisation - merely posting them on a bulletin board and paying them lip service is not tolerated! 'Living' these values in our day-to-day business activities provides us with the foundation of what is important to us - namely, providing world-class patient care.
Accountability
We ensure employees know what they are responsible for and are empowered to deliver.
Collaboration
We maximise our achievements as a group, not as individuals.
Transparency
We believe that visible problems can be solved and that informed people make better decisions.
Stretch
We continuously push the boundaries of performance."
Another entry on the website reads:
"Quality
Afrox Healthcare's quest is to maintain world-class quality standards at all its hospital facilities - to the benefit of its patients, employees, supporting medical practitioners and funders. A world-class quality management process
We believe that our unique process of managing quality standards in our hospitals matches and probably exceeds the best to be found anywhere in the world today.
The Afrox total quality management (TQM) process was launched throughout the company in 1993, exposing each and every employee to the company's vision for quality management. The Healthcare division then adapted the programme to satisfy the unique demands of the healthcare industry.
The programme incorporates a vision, policies and procedures, critical success factors with supporting key performance indicators and specified activities. It is reviewed and upgraded on an ongoing basis. Continued adherence to these standards has been maintained by encouraging each and every employee to participate fully in the process and contribute to the decision-making processes. All new employees are exposed to the process as part of their induction training.
Today, Afrox Healthcare and its member hospitals are reaping the rewards of this visionary approach to quality management. A culture of service excellence, a spirit of teamwork amongst all levels of staff and a continuous quest for improvement are now firmly entrenched. This, in turn, means that patients, funders and supporting medical practitioners can rely on our consistently high standards in all disciplines associated with hospital management, particularly nursing care. We also embarked on a scientific quality improvement programme at the Eugene Marais Hospital during 1997. This ward resource management program has now been implemented in most Afrox Healthcare hospitals with both input and output measures based on quality improvement. This program ensures quality care through resource and standards management."

130 An article from the website (see fn above) states: "The Afrox College of Nursing has invested millions in the training of world-class nurses and the establishment of learner centres countrywide. After four years of offering accredited diploma courses and supplying Afrox Healthcare's hospitals with highly skilled nurses, the college has now opened its doors to external students.
"Undoubtedly, the most serious challenge to the healthcare industry is the drain on specialized and experienced nursing skills. As a member of the private healthcare sector, we accept responsibility to implement initiatives to develop and train nurses, which will contribute to the skills development and empowerment of our people, and to create an environment in our hospitals which will attract, support and retain quality nurses," said Michael Flemming, managing director of Afrox Healthcare Limited.
One such initiative is the Afrox College of Nursing, which entered into a groundbreaking partnership with the University of Port Elizabeth four years ago to ensure that the high nursing standards, which are a hallmark within the Afrox Healthcare group, are continued into the new millennium. Outcomes-based learning and training and the development of skills and competencies is a priority within the group's hospitals.
"The college has gone from strength to strength and we have taken up the challenge to ensure the ongoing provision of highly qualified nursing staff to the more than sixty Afrox Healthcare hospitals across the country. We want to pay tribute to our nurses for their exceptional level of professionalism and unwavering commitment towards quality patient care," said Sharon Vasuthevan, training manager, at a nursing diploma ceremony held in Johannesburg.
"Student numbers have increased dramatically. More than 1 000 nurses have graduated from the college by 2002, and 488 are enrolled at present. In the last week, 150 students graduated from the college, and for the first time, 30 external students have enrolled this year for the four-year diploma in nursing. We are now the largest private nursing training institution in South Africa with nine learner centres in Johannesburg, Pretoria, Bloemfontein, Durban, Witbank, Klerksdorp, East London, Port Elizabeth and Cape Town. All practical nursing training takes place in the Afrox Healthcare hospitals, which ensures that learners are exposed to new technologies and the highest standards of quality care."
"Our numerous successes last year include training more than double the number of critical care and theatre nurses than the previous year. We offer basic and post-basic diploma courses in areas such as critical care, operating theatre, emergency, orthopaedic and general nursing," Sharon said. "Community involvement is very important for us, and the group's community involvement projects will be extended to all nine learner centres this year. This fits in with Afrox Healthcare's philosophy of building sincere and meaningful partnerships with the communities in which we operate," Sharon said. Students at the learner centres are also actively involved with local organisations and regional initiatives.

hospitals in South Africa the norm and that they have been doing it for many years – certainly at the time when the case under discussion was decided. From a policy perspective and given this kind of advertising why should a layperson entering such a hospital as a patient expect a clause such as 2.2 to be contained in the admission documentation? It is submitted with respect to the Supreme Court of Appeal that entering a hospital for medical treatment and enlisting the services of a plumber to address a household plumbing problem are two extremely different activities on the basis of risk. One cannot thus say that all suppliers of services are the same and that what is good for one is good for all. The nature of the service they render directly affects the nature and extent of the personal risk to the customer represented by that service. The South African courts have distinguished between different levels of risk even within the healthcare environment for instance with regard to the mode of delivery of a medicine – intravenously or per mouth. The effect of this judgment of the Supreme Court of Appeal is that every single private hospital in South Africa will include such a clause in its admission documentation with the result that, even assuming a patient did have some degree of bargaining power, the chances patients ever having recourse in South Africa against a private hospital for the negligent acts of its employees are now – negligible. The salary levels of nurses in South Africa are likely to mean that a lawsuit against an individual nurse would not effectively assist any patient in the recovery of compensation for his loss. Most nurses are not millionaires whilst the damages arising from medical negligence can run into hundreds of thousands of rands, if not millions, in some cases.

The court's failure to recognise the importance of the fact that private hospitals can be distinguished from other suppliers on the basis that the former provide services which are the subject of a constitutional right – a right moreover- which seeks to ensure access to those services- is also regrettable. The court chose to take a very narrow view of the issue of access holding that the clause did not interfere with access to health care services in that it did not have the effect of barring anyone from obtaining health care services. It is submitted with respect that this view of access is overly simplistic given the nature of the services one is dealing with. Health care services are generally required to promote, maintain or improve the health of a patient. When the

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Last year, learners at the Bloemfontein centre took part in a mock disaster exercise staged by the SANDF, emergency, fire and ambulance services and staff from provincial and private hospitals.

courts consider claims in delict on the basis of medical negligence they do not adopt an approach which says that if the patient would in any event have ended up in his final state if there had been no medical intervention then one cannot hold a health professional liable for his negligence in preventing this from happening. In other words the law expects a health professional to act in such a way as to improve the patient's situation. Admittedly the improvement is not guaranteed but that is not the point. The point is that the health professional must act in the way in which any other reasonable health professional in the position of the health professional would act. Since such action is invariably geared towards and aimed at improving the patient's condition, as opposed to aggravating it, the reasonable expectation of the person receiving health services is that they will be beneficial in some way – even if only to alleviate symptoms. Access to health care services is not access in the constitutional sense, where that access is not of such a nature that it is intended to, and administered in such a way as to, benefit the patient. It is submitted that a narrow construction of the meaning of access to health services, so as to permit them to be rendered in conditions which in themselves put the life or health of the patient at risk, defeats the object of the constitutional right contained in section 27(1) of the Constitution. Access to health care services requires access to skilled and diligent health professionals using tried and generally accepted or recognized techniques - not charlatans and mountebanks or even well meaning laypersons. It is submitted with respect, that to accept otherwise is to contradict the long established principles of the common law of delict as well as the Constitution. The courts do not uphold contracts which are contrary to public policy or to the legal convictions of the community as expressed in the *boni mores*. There are certain obligations which it should be inescapable and which should certainly not be applied in situations where the bargaining power of the contracting parties is so unequal as to be non-existent on the side of the one. The boni mores do not alter depending upon whether one is dealing with the law of contract or the law of delict. The public policy considerations are the same in both areas of law. It is extremely difficult to see why the broader community, as opposed to the business community with which the Supreme Court of appeal seemed primarily concerned in this case, would prefer the right to freedom of contract to the right of access to effective and properly delivered health care services. It is submitted that the Supreme

Court of Appeal demonstrates not only in this case but also in others such as *Carmichele*[131] a surprising and unfortunate reluctance to take opportunities to align the more traditional common law principles with the Constitution[132] and that within this court, judicial inertia is the order of the day.

Section 9 of the Occupational Health and Safety Act[133] provides for general duties of employers and self-employed persons to persons other than their employees as follows-

"(1) Every employer shall conduct his undertaking in such a manner as to ensure, as far as is reasonably practicable, that persons other than those in his employment who may be directly affected by his activities are not thereby exposed to hazards to their health or safety.
(2) Every self-employed person shall conduct his undertaking in such a manner as to ensure, as far as is reasonably practicable, that he and other persons who may be directly affected by his activities are not thereby exposed to hazards to their health or safety."

It is therefore a statutory as well as a common law liability that one is dealing with when considering the liability of private hospitals and other health care institutions for the professional negligence of their staff. It is submitted that the wording of section 9 is wide enough to include a responsibility of an employer of health care professionals to ensure that they are not negligent in the delivery of health care services to patients.

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131 *Carmichele v Minister Of Safety And Security And Another* 2001 (1) SA 489 (SCA). See the criticism of the Constitutional Court in *Carmichele v Minister Of Safety And Security And Another (Centre For Applied Legal Studies Intervening)* fn 115 *supra* in which it was held that since all Courts were constitutionally obliged to promote the spirit, purport and objects of the Bill of Rights when developing the common law, they were compelled to eliminate any common-law deviation from these aims. The proceedings in the High Court and SCA took place after the new Constitution had come into operation and both Courts had, in assuming that the pre-constitutional test for wrongfulness of omissions in delictual actions should be applied, overlooked the demands of s 39(2) of the Constitution. See also *Bannatyne v Bannatyne (Commission For Gender Equality, As Amicus Curiae)* 2003 (2) SA 363 (CC)

132 Brand D in 'Disclaimers in Hospital Admission Contracts and Constitutional Health Rights: Afrox Healthcare v Strydom' *ESR Review* Vol 3 No 2 September 2002 published by the Socio-Economic Rights Project, University of the Western Cape states that: "The Court's judgment puzzles. The Court's finding that there was equality of bargaining power ignores the self-evident inequality inherent in the contractual relationship. It is submitted that the nature of the service at stake created an unequal bargaining position. One cannot do without health care services, which are a fundamental constitutional right. Since all private and public hospitals in South Africa use indemnity clauses, it is clear that the respondent had no bargaining power regarding the indemnity clause – if he objected to it he had nowhere else to go and would not have gained access to health care services. The Court's reasoning on the clash between the indemnity clause and constitutional values is equally suspect. The Court concluded that, in the absence of the threat of action for damages, disciplinary action by professional bodies and concern for a hospital's reputation ensure that hospitals avoid negligent conduct. The Court's reasoning ignores the fact that the respondent litigated precisely because of negligence that occurred despite these 'sanctions' and that caused the respondent damage, for which he cannot now be compensated. In addition, the case seemed significant because it concerned the indirect horizontal application of a socio-economic right. It allowed the Court an opportunity to demonstrate its regard for constitutional values. However, the judgement raises doubt as to the extent to which the Court considers these values. This observation is most evident in the consideration of whether the indemnity clause offends public policy. This consideration comes down to a balancing of the individual interests of the contracting parties and the general, constitutional interests of the public. The Court opted for the protection of individual (commercial) interests while ignoring almost completely the fact that the service the parties bargained about was a constitutional right. With regard to the scope of the limits engendered by an indemnity clause, the Court held that those limits should be defined by business considerations such as saving in insurance premiums and competitiveness… The Court missed an opportunity: it again insulated that common law from constitutional infusion."

133 Act No 85 of 1993

Every employer must conduct his undertaking in a particular manner. That manner is to ensure as far as is reasonably practicable that persons other than employees who may be directly affected by his activities are protected. The protection in question relates *expressly* to hazards to their *health* or safety. This Act provides expressly for the vicarious liability of employers for acts of their employees in certain circumstances in section 37[134]. It is submitted that to the extent that legislation can be regarded as indicative of public policy concerns and the legal convictions of the community, the Supreme Court of Appeal erred in taking the opposite view that the employer could contract out of liability in these particular circumstances, relating as they did to the health and safety of persons directly affect by the employer's activity of running a private hospital and offering health care services to the general public therein. In terms of section 38(1) of this Act any person who contravenes or fails to comply with *inter alia* a provision of section 9 is guilty of an offence and on conviction is liable to a fine not exceeding R50 000 or to imprisonment for a period not exceeding one year or to both such fine and such imprisonment[135]. It is pointed out in the chapter on the law of delict that the test for wrongfulness is the same for both

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134 "37 Acts or omissions by employees or mandataries

(1) Whenever an employee does or omits to do any act which it would be an offence in terms of this Act for the employer of such employee or a user to do or omit to do, then, unless it is proved that-

(a) in doing or omitting to do that act the employee was acting without the connivance or permission of the employer or any such user;

(b) it was not under any condition or in any circumstance within the scope of the authority of the employee to do or omit to do an act, whether lawful or unlawful, of the character of the act or omission charged; and

(c) all reasonable steps were taken by the employer or any such user to prevent any act or omission of the kind in question,

the employer or any such user himself shall be presumed to have done or omitted to do that act, and shall be liable to be convicted and sentenced in respect thereof; and the fact that he issued instructions forbidding any act or omission of the kind in question shall not, in itself, be accepted as sufficient proof that he took all reasonable steps to prevent the act or omission.

(2) The provisions of subsection (1) shall *mutatis mutandis* apply in the case of a mandatary of any employer or user, except if the parties have agreed in writing to the arrangements and procedures between them to ensure compliance by the mandatary with the provisions of this Act.

(3) Whenever any employee or mandatary of any employer or user does or omits to do an act which it would be an offence in terms of this Act for the employer or any such user to do or omit to do, he shall be liable to be convicted and sentenced in respect thereof as if he were the employer or user.

(4) Whenever any employee or mandatary of the State commits or omits to do an act which would be an offence in terms of this Act, had he been the employee or mandatary of an employer other than the State and had such employer committed or omitted to do that act. he shall be liable to be convicted and sentenced in respect thereof as if he were such an employer.

(5) Any employee or mandatary referred to in subsection (3) may be so convicted and sentenced in addition to the employer or user.

(6) Whenever the employee or mandatary of an employer is convicted of an offence consisting of a contravention of section 23, the court shall, when making an order under section 38 (4), make such an order against the employer and not against such employee or mandatary."

135 Section 39(2) of the Occupational Health and Safety Act stipulates that: "Any employer who does or omits to do an act, thereby causing any person to be injured at a workplace, or, in the case of a person employed by him, to be injured at any place in the course of his employment, or any user who does or omits to do an act in connection with the use of plant or machinery, thereby causing any person to be injured, shall be guilty of an offence if that employer or user, as the case may be, would in respect of that act or omission have been guilty of the offence of culpable homicide had that act or omission caused the death of the said person, irrespective of whether or not the injury could have led to the death of such person, and on conviction be liable to a fine not exceeding R100 000 or to imprisonment for a period not exceeding two years or to both such fine and such imprisonment.

criminal law and the law of delict. It is ironic that a patient in the position of Strydom who can show a violation of section 9 of the Occupational Health and Safety Act would not, in the presence of an indemnity clause such as that in *Afrox Healthcare v Strydom* be able to obtain damages in delict but the public prosecutor might be able to secure a criminal conviction in terms of occupational health legislation.

6.2.9 Oldwage v Louwrens[136]

Facts

The plaintiff was admitted at Panorama Medi-Clinic (Panorama) 7 June 2000, a day preceding the date of the operation. On that day the defendant performed an angiogram on him. The operation was performed the following day. The plaintiff was discharged from Panorama on Sunday, 11 June 2000. On discharge from hospital, the plaintiff was not relieved of pain he experienced prior to the operation. On Wednesday, 14 June 2000 the plaintiff consulted a Dr Kieck, a neuro-surgeon, in his rooms at Vincent Pallotti Hospital, Pinelands. Dr Kieck examined the plaintiff and diagnosed a prolapsed disc as the source of the pain that the plaintiff experienced at the time. On 21 June 2000 and at Vincent Pallotti, Dr Kieck performed a laminectomy on the plaintiff. The plaintiff remained in Vincent Pallotti until Sunday, 24 June 2000, on which latter date he was discharged and relieved of pain. A few days after his discharge from Vincent Pallotti and in an attempt to do some physical exercise, as he was accustomed to do prior to undergoing the vascular operation, the plaintiff went for a walk with his wife when he discovered that, after walking a short distance of about 30m, he experienced cramps and pain in his left leg. This obliged the plaintiff to rest, but the pain would recur as soon as he resumed walking. The plaintiff subsequently saw Dr Kieck for a follow-up operation on Monday, 3 July 2000. On this occasion Dr Kieck noted that the plaintiff 'claudicates'. Dr Kieck further noted that the plaintiff's left foot was cold to touch; that the pulses in the left leg were negative and that, according to the plaintiff, this symptom manifested after the

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136 *Oldwage:* As yet unreported case no 10253/01in the Cape Provincial Division of the High Court judgment handed down on 19 February 2004

vascular operation. In the course of trial it became apparent that when the plaintiff consulted the defendant and was subsequently operated on, the plaintiff presented with extensive vascular disease. When pain persisted after this operation, he consulted Dr Kieck who diagnosed a prolapsed disc in the L4/5 lumbar region as a source of pain necessitating a laminectomy which Dr Kieck performed on 21 June 2000. The plaintiff thus not having been relieved of the pain he experienced after the vascular operation, the primary issue the court had to determine, amongst other ancillary issues, is what medical intervention, if any, was reasonably required to address the pain the plaintiff experienced prior to the performance of the two operations on him.

The plaintiff's health history was such that except for a laminectomy which was performed on him at Dundee, in the Province of Kwazulu Natal during 1972, he was otherwise fit and healthy up until 27 April 2000 when he sustained an injury to his back in Cedarberg, Clanwilliam, Cape. At that stage the plaintiff and his wife occupied a flat in Milnerton. The flat was situated on the fourth floor of a block of flats and could only be accessed by four flights of stairs. The plaintiff utilized a flat on the second floor of the same building as an office. During December 1999 the plaintiff purchased two mountain bicycles – one for himself and one for his wife. This, so the plaintiff testified in evidence, was at the suggestion of his wife in order that they could exercise regularly. At regular intervals, the plaintiff and his wife would visit the Clanwilliam Dam area where they would either stay with the plaintiff's brother, George, or would stay at a house referred to in evidence as "The Thatch Roof House". During such visits, the plaintiff would undertake regular exercise activities such as walks and bicycle rides. On one such visit on the long weekend commencing 27 April 2000 the plaintiff and his wife went for a walk next to the Clanwilliam Dam when, during such a walk, the plaintiff slipped landing on his buttocks and hurting his lower back in the process. The plaintiff was laid up for the rest of that long weekend with significant backache. As a result of this incident, the plaintiff and his wife returned to Cape Town earlier than anticipated due to discomfort and inconvenience the plaintiff experienced subsequent to the slipping incident. On his return to Cape Town, the back injury was treated conservatively by way of bed rest and after a few days the plaintiff resumed work as before. Towards the end of May 2000 the plaintiff experienced increasing and later intense pain in his right leg.

On 5 June 2000 he visited Dr Simons, a general practitioner, for the first time. While waiting in the reception room prior to seeing Dr Simons, the plaintiff did not sit down, but leaned against the wall or a table. This was because of severe pain he experienced at the time. When the plaintiff subsequently consulted Dr Simons he complained of five days of pain in the lower aspect of the right leg which was preceded by numbness especially when getting out of bed; the pain was aggravated by movement and radiated up to the right buttock. Dr Simons performed a single leg raise test on the plaintiff. Dr Simons neither made notes regarding any complaint of claudication on the part of the plaintiff, any pain in the right foot, discolouration of the right foot, abnormal temperature in the right foot nor the precise nature of any neurological tests he may have performed. Dr Simons referred the plaintiff to the defendant for an appointment at the latter's rooms at Panorama on Tuesday, 6 June 2000. The plaintiff duly visited the defendant as arranged. He took a taxi because it would have been too uncomfortable to drive because of pain. The plaintiff handed to the defendant a note sealed in an envelope given to him by Dr Simons. The contents of this note were not known as it was neither discovered nor produced in evidence. The defendant had in the meantime departed for a conference in America and had left Plaintiff in the care of Dr Michaelowsky. On discharge from Panorama, the plaintiff was seen by Dr Michaelowsky. Shortly before his discharge the plaintiff told Dr Michaelowsky that he continued to experience a similar pain in his right leg to that which he had experienced before the operation. According to the plaintiff Dr Michaelowsky's response was that the plaintiff should give it time. The plaintiff's wife, who had gone to the hospital to collect him, overheard this discussion. The discussion took place whilst Dr Michaelowsky examined the plaintiff prior to his discharge. On his discharge, the plaintiff was unable to walk very far and had to make use of a wheelchair when leaving the hospital. Upon returning to his flat that Sunday morning, the plaintiff ascended the flight of stairs with great difficulty. He had to be supported throughout by his wife. It was necessary for them to rest on a chair at each landing along the way. The plaintiff continued to complain about pain in his right leg until Monday, 12 June 2000. He directed various telephone calls to Dr Simons in an endeavour to discuss the ongoing discomfort with him. Dr Simons eventually spoke to the plaintiff late in the afternoon on Monday, 12 June 2000. The following day Dr Simons attended to the plaintiff who was then in his office on the second floor and examined him on a makeshift couch. The plaintiff's wife testified that the plaintiff

complained to Dr Simons that the pain in the right leg was now worse than before and that, on this occasion, his left foot was cold. Dr Simons corroborated the plaintiff's wife's evidence in this regard. He prescribed certain analgesic drops and told the plaintiff to give the leg time to recover. In a state of frustration, the plaintiff then proceeded to telephone a number of medical specialists in an attempt to obtain advice regarding his pain. He eventually made contact with Dr Freddie Kieck's rooms whereafter an appointment was set up for the following day. The plaintiff saw Dr Kieck in his rooms at the Vincent Pallotti Hospital in Pinelands on Wednesday, 14 June 2000. After a Magnetic Resonance Imaging (MRI) scan, Dr Kieck diagnosed a large rupture of the L4/5 disc with root compression. Dr Kieck advised that the plaintiff undergo surgery within the next week to alleviate the pain. Dr Kieck's handwritten notes taken in that consultation recorded a slight pain of approximately a week in the plaintiff's right lateral calf which got worse after three days; an *"on/of"* back problem which manifested for three to four weeks every few years; acute backache for two weeks in April 2000 when the back was out; the plaintiff's general practitioner thought he was suffering from peripheral vascular disease; the plaintiff had undergone iliac femoral by-pass the previous week; the original pain was still there; that it was terrible and presented in the buttock/thigh/calf and that the plaintiff was more comfortable at rest while bending was worse. Upon examination Dr Kieck noted that the plaintiff experienced pain; the leg-raise examination on the right leg was limited to 30 degrees and the plaintiff's pulses on the right were recorded as positive while those on the left were recorded as negative. On the same day, Dr Kieck addressed a letter to Dr Simons in which he set out full details of his observations and proposed management of the problem. Although the letter was addressed to Dr Simons at his fax number at his rooms, Dr Simons denied receiving the fax. The plaintiff continued to experience pain in his right leg for the following week. On Wednesday, 21 June 2000, Dr Kieck operated on the plaintiff's back and performed a right L4 laminotomy. Dr Simons assisted in that operation but did not see the plaintiff at any stage between 15 and 21 June 2000, nor did he inform the plaintiff that he was aware of the intended operation or of the fact that he had been invited by Dr Kieck to assist therein. The plaintiff was immediately pain free after the lumbar operation and was discharged from Vincent Pallotti on Saturday, 24 June 2000. When returning home on that occasion the plaintiff was able to ascend the four flights of stairs to his flat with much greater ease than after the first operation. A few days after the plaintiff

had been discharged from Vincent Pallotti he attempted to recommence exercising and went for a walk with his wife. The plaintiff would have proceeded very gingerly due to the operation wounds. During his first walk the plaintiff immediately showed signs of claudication in his left leg. After taking an oral history the defendant examined the plaintiff on his examination couch. The plaintiff did not remove his trousers as it was too painful to do so. The defendant examined the plaintiff in the groin by loosening the plaintiff's trousers. The defendant examined the plaintiff's right foot. In the consultation preceding the examination, the defendant did not ask the plaintiff whether he had experienced any symptoms of claudication nor did he take any record of the plaintiff's exercise regime or eating habits. The defendant did not perform a Doppler test on the plaintiff. The plaintiff did not mention the fall in Cedarberg to the defendant, nor did the defendant direct any enquiry to the plaintiff which would have elicited that information. After examining the plaintiff, the defendant held the view that the plaintiff was suffering from a problem with his vascular circulation resulting in blockages in his arteries, that the problem could be addressed by the insertion of a balloon into the plaintiff's arteries or a graft to replace certain of the blocked veins in the body with a plastic prosthesis and that further tests were required before the defendant could determine which surgical procedure would be appropriate. The plaintiff went home and returned the following day when an electrocardiogram (ECG) was performed and after he was given a sedative later in the day, the defendant performed an angiogram on him. The angiogram confirmed an occlusion of various arteries in plaintiff's right iliac system, the internal iliac artery and the superficial femoral artery in the left leg. He was subsequently admitted to the ward. plaintiff was informed that a by-pass operation was necessary to relieve him of his pain. An operation was performed on the plaintiff by the defendant some time between 08h45 and 12h45 on the morning of Thursday, 8 June 2000. As has already been pointed out, the plaintiff was discharged on Sunday, 11 June 2002 still not relieved of pain he experienced prior to the performance of the operation. The plaintiff saw Dr Kieck for a follow-up consultation on Monday, 3 July 2000. During that consultation Dr Kieck noted that Plaintiff claudicated in the left leg after walking a distance of 30 metres; that the left foot was cold to touch; the pulses in the left leg were negative and that the claudication had manifested after the vascular operation. In the meantime the defendant had returned from his trip abroad and was back at work on Monday, 19 June 2000. His appointment book for Tuesday, 20 June 2000 indicates

that an appointment he had with the plaintiff at 14h30 on that day had been cancelled. The defendant was to have telephoned Dr Kieck on that day. The defendant's appointment book for Thursday, 22 June 2000, reflects that the defendant was to have telephoned Dr Kieck. Dr Kieck would have performed the laminectomy a day before. Judging by the tick next to Dr Kieck's name and telephone number, it would appear that the call was indeed made. On Monday, 26 June 2000 the defendant wrote a letter to Dr Simons in which letter the defendant sets out details of the consultation he had with the plaintiff on Tuesday, 6 June 2000. An analysis of the angiogram performed on Wednesday, 7 June 2000 and the particulars of the by-pass operation performed on Thursday, 8 June 2000. The letter concluded that the defendant was aware of the lumbar surgery performed on the plaintiff by Dr Kieck and concluded with the following sentence:

"This may be a case of double pathology but I hope that he will now be able to return to work."

On Tuesday, 4 July 2000 the plaintiff saw the defendant in the reception area of his rooms. The plaintiff stated in his evidence that the defendant did not examine him whilst the defendant, was adamant that he examined the plaintiff on this last occasion. According to the plaintiff no examination was conducted but merely a discussion relating to the plaintiff's then current complaint of claudication. The plaintiff, by all accounts, had lost confidence in the defendant by this time. According to the plaintiff the defendant informed the plaintiff that the claudication problem could not have been foreseen during the vascular operation and that there was nothing that could be done to remedy the problem. Instead the defendant advised the plaintiff to lead a healthier lifestyle. The plaintiff also informed the defendant of the back operation he had undergone and of the subsequent pain relief in his right leg. On the same day that the plaintiff saw the defendant, the latter wrote a further letter to Dr Simons in which letter he (the defendant), for the first time, mentioned the complaint of claudication. The letter further records that on examination all pulses were present in the right leg; only a femoral pulse was apparent in the left leg and that a total occlusion of the superficial femoral artery was the likely cause of the plaintiff's symptoms of claudication.

The plaintiff claimed that in breach of the agreement between the parties the defendant failed to exercise the degree of care and skill required of a specialist vascular surgeon in that defendant:

1. failed to take a full and proper medical history, inter alia, regarding the "pinched nerve" complaint;
2. failed to examine Plaintiff adequately;
3. failed to diagnose Plaintiff's symptoms correctly;
4. failed to appreciate that the Plaintiff's symptoms were indicative of nerve compression in the lumbar region with referred pain down the leg;
5. failed to appreciate that the co-existence of vascular and neuropathic pathology is perfectly possible and not uncommon and that his symptoms at that stage were not related to vascular insufficiency;
6. failed to refer Plaintiff to an appropriate speciality for further treatment;
7. failed to procure Plaintiff's informed consent by *inter alia* failing to advise, warn and inform Plaintiff that:
8. The proposed femoro-femoral by-pass operation had a well known complication of possible claudication of the left leg;
9. The status of the left leg (vascular occlusion) presented a high probability that the aforesaid complication would ensue;
10. The alternative procedure of an aorto bifemoral plus femero-popliteal by-pass was available and much more appropriate under the circumstances;
11. Failed to perform the correct procedure in respect of the presenting complaint;
12. Failed to perform the more appropriate procedure to remedy the underlying vascular occlusion;

Alternatively, and in any event Defendant, in breach of his aforesaid duty of care, unlawfully and negligently acted as set out in the preceding paragraphs.

Alternatively the plaintiff averred that:

1. The plaintiff agreed to undergo the aforesaid femoro-femoral by-pass operation as a result of the defendant presenting to the plaintiff that such operation was essential and that, if the plaintiff did not undergo such operation, the plaintiff

would not recover from certain medical complications that the plaintiff was at the time experiencing.

2. The said representation was false in that the aforesaid procedure was not essential and in that the plaintiff did not require the said procedure in order to recover from the medical complaints that the plaintiff was suffering from;

3. The said representation was material and made with the intention of inducing the Plaintiff to agree to the aforesaid procedure. Relying on the truth thereof, the plaintiff did so agree;

4. The said representation was negligently made by the defendant, having regard to the defendant's professional skill and expertise and the information which could, upon a reasonable enquiry, have been obtained by the defendant which would have shown that the said representation was untrue;

Alternatively to the foregoing, and in any event, by reason of the fact that the plaintiff was not informed of the aspects set out in paragraph 6.7.1 to 6.7.3 above, it was alleged that the plaintiff's alleged informed consent to the operation performed on the 8th of June 2000 was not procured and such operation accordingly constituted an assault on the plaintiff.

Judgment

The court stated that the issues which, in the final analysis, call for determination are whether the defendant acted in breach of his obligation arising from the agreement entered into between plaintiff and the defendant, whether the defendant misrepresented to plaintiff that the vascular procedure performed would relieve plaintiff of the severe pain; whether the plaintiff consented to such procedure and if no consent was given or proved whether, in that event, the defendant's conduct constitutes assault rendering him liable for whatever damages the plaintiff might prove. A finding on these latter issues, said the court, has to be preceded by a finding

as regards what medical intervention, if any, was reasonably required to address the plaintiff's complaint regarding pain during the period Monday, 5 June 2000 to Thursday, 8 June 2000.

Yekiso J canvassed the disputes of fact and referred in this regard to the decision of the Supreme Court of Appeal in *SFW Group Ltd and Another v Martell et Cie & Others*[137]. He noted that as an alternative cause of action the plaintiff averred that he agreed to undergo the surgical procedure performed as a result of a false or negligent misrepresentation by the defendant, such misrepresentation having been made with the intention to induce the plaintiff to agree to the procedure performed, and, relying on the truth thereof, the plaintiff did agree to undergo the operation. The plaintiff thus averred that because of such false or negligent misrepresentation he acted to his detriment and consented to the vascular surgery performed and that such consent, because of such misrepresentation, was not properly informed. Yekiso J then made some observations about the general principles applicable to the question of breach of duty or otherwise negligence on the part of a medical practitioner both in his or her pre-operative advice, performance of surgery and in the post-operative treatment of a patient. He observed that Innes, ACJ, as he then was, held as far back as 1914 -

"that a medical practitioner is not expected to bring to bear upon the case entrusted to him the highest degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not. The burden of proving that the injury of which he complains was caused by the Defendant's negligence, rested throughout upon the Plaintiff. The mere fact that the accident occurred was not itself *prima facie* proof of negligence." (See *Mitchell v Dixon*[138])

and that at p526, the learned judge further observed -

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137 *Martell* 2003 (1) SA 11(SCA) at p 141 par 5:"The technique generally employed by courts in resolving factual disputes of this nature may conveniently be summarised as follows. To come to a conclusion on the disputed issues a court must make findings on (a) the credibility of the various factual witnesses; (b) their reliability and (c) the probabilities. As to (a) the court's finding on the credibility of a particular witness will depend on its impression about the veracity of the witness. That in turn will depend on a variety of subsidiary factors, not necessarily in order of importance, such as (i) the witness' candour and demeanour in the witness-box, (ii) his bias, latent and blatant, (iii) internal contradictions in his evidence, (iv) external contradictions with what was pleaded or put on his behalf, or with established fact or with his own extracrucial statements or actions, (v) the probability or improbability of particular aspects of his version, (vi) the calibre and cogency of his performance compared to that of other witnesses testifying about the same incident or events. As to (b), a witness' reliability will depend, apart from the factors mentioned under (a)(ii), (iv) and (v) above, on (i) the opportunities he had to experience or observe the event in question and, (ii) the quality, integrity and independence of his recall thereof. As to (c), this necessitates an analysis and evaluation of the probability or improbability of each party's version on each of the disputed issues. In the light of its assessment of (a), (b) and (c) the court will then, as a final step, determine whether the party burdened with the *onus* of proof has succeeded in discharging it. The hard case, which will doubtless be the real one, occurs when a court's credibility findings compel it in one direction and its evaluation of the general probabilities in another. The more convincing the former, the less convincing will be the latter. But when all factors are equipoised probabilities prevail."

138 *Mitchell* 1914 AD 519 at 525

"... a medical practitioner is not necessarily liable for wrong diagnosis. No human being is infallible: and in the present state of science, even the most eminent specialist may be at fault in detecting the true nature of a diseased condition. A practitioner can only be held liable in this respect, if his diagnosis is so palpably wrong as to prove negligence, that is to say, if his mistake is of such a nature as to imply an absence of reasonable skill and care on his part, regard being had to the ordinary level of skill in the profession."

Yekiso J observed that as Strauss correctly points out, this *dictum* still holds good today although medical science has made tremendous strides since 1914 and today's technological aids being vastly superior to those in 1914, that despite such technological advances of our century, medicine still is not - and probably never will be – an exact science comparable to mathematics. Much depends on the skill and experience of the individual practitioner[139].

He noted that the principle enunciated in *Mitchell v Dixon* supra was followed in a number of subsequent decisions, notably *Buls and Another v Tsatsarolakis*[140]; *Correira v Berwind*[141]; *Castell v De Greeff*[142] amongst others. Foreign case law, in particular judgments of the English courts, although generally do not constitute a binding precedent to our courts, have always had considerable persuade force and are often referred to by our courts[143]. In *Whitehouse v Jordan* the English Appeal Court held that a "mere error of judgment" on the part of a medical practitioner does not constitute negligence. In this regard Ackerman J in *Castell v De Greeff*[144] said the following:

"It has on occasions been suggested that a 'mere error of judgment' on the part of a medical practitioner does not constitute negligence. In *Whitehouse v Jordan and Another* (1981) I All ER 267(HL) the House of Lords, *inter alia*, considered the correctness of the statement by Denning MR in the Court of Appeal that:
'We must say, and say firmly, that, in a professional man an error of judgment is not negligence.'
The House of Lords held this to be an inaccurate statement of the law. At 281a Lord Fraser of Tullybelton expressed the view that: *"I think Lord Denning MR must have meant to say that an error judgment 'is not necessarily negligent'."*

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139 Strauss SA *Doctor Patient and the Law* 3rd edition 1999 at p 252
140 *Buls* 1976 (2) SA 891(T)
141 *Correira* 1986 (4) SA 60(ZHC);
142 *Castell* 1994 (1) SA 408(C)
143 See *Castell v De Greeff* fn 142 *supra* at p 416 and a reference therein to the judgment of the English Appeal Court and the House of Lords in *Whitehouse v Jordan and Another* (1981) 1 All ER 267(HL)
144 *Castell* fn 142 *supra* at p416 E-H

Lord Fraser further observed as follows (at 281b): "Merely to describe something as an error of judgment tells us nothing about whether it is negligent or not. The true position is that an error of judgment may, or may not, be negligent; it depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that a man, acting with ordinary care, might have made, then it is not negligent."

With these principles in mind, Yekiso J proceeded in the determination and the resolution of the areas of dispute adopting the approach as stated by the Supreme Court of Appeal in *SFW Group & Another supra*, and to determine whether the defendant's conduct in his pre-operative advice, performance of surgery and post-operative treatment of the plaintiff, if any, was culpable, and if so, whether such culpability attracted any form of liability. There was conflicting evidence from the expert witnesses in this case. Yekiso J observed that the approach to follow in the evaluation of conflicting expert evidence pertaining to the alleged professional negligence of a medical practitioner was recently restated by the Supreme Court of Appeal in *Michael & Another v Linksfield Park Clinic (Pty) Ltd & Another*[145]. On a question of how one establishes the conduct and views of the notional reasonableness of a medical practitioner without a collective or representative opinion, the Court held as follows:

"That being so, what is required in the evaluation of such evidence is to determine whether and to what extent their opinions advanced are founded on logical reasoning. That is the thrust of the decision of the House of Lords in the medical negligence case of *Bolitho v City and Hackney Health Authority* [1998] AC 232 (HL (E). With the relevant *dicta* in the speech of Lord Browne-Wilkinson we respectfully agree. Summarised, they are to the following effect. The court is not bound to absolve a defendant from liability for allegedly negligent medical treatment or diagnosis just because of evidence of expert opinion, albeit genuinely held, is that the treatment or diagnosis in issue accorded with sound medical practice. The court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and has reached 'a defensible conclusion' 9at 241G – 242B).A defendant can properly be held liable, despite the support of a body of professional opinion sanctioning the conduct in issue, if that body of opinion is not capable of withstanding logical analysis and is therefore not reasonable. However, it will very seldom be right to conclude that views genuinely held by a competent expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which the court would not normally be able to make without expert evidence and it would be wrong to decide a case by simple preference where there are conflicting views on either side, both capable of logical support. Only where expert opinion cannot be logically supported at all will it fail to provide 'the benchmark by reference to which the defendant's conduct falls to be assessed' (at 243A-E)."

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145 *Michael* 2001(3) SA1188 (SCA) at p1200 par 36

Yekiso J analysed the expert evidence and came to the conclusion that, based on these views and the probabilities based on evidence, the nature of pain the plaintiff experienced both pre and post the vascular operation was of a neuralgic nature and not of a vascular origin. On discharge from Panorama the plaintiff was not relieved of pain. The relief only came about after the plaintiff had undergone laminectomy at Vincent Pallotti. The pain was ongoing before and after the vascular operation and the relief only came about after the laminectomy was performed. Yekiso J observed that the plaintiff's complaints, in his view, ought to have excited a suspicion that all was not well and that the source of the plaintiff's pain could not have been from the source originally anticipated and, accordingly, would have justified a further investigation which probably would have involved referral of the plaintiff to a neurosurgeon. He noted that Professor De Villiers' (one of the expert witnesses) evidence was that if the defendant had diagnosed the neuralgic pain, the defendant in all probability would have referred the plaintiff to a neurosurgeon, and if that had been done, the neurological problem would have been addressed first. He was thus of the view that when the plaintiff consulted the defendant on Tuesday, 6 June 2000, he presented two conditions, namely, that of an extensive vascular disease and a neurological problem arising from the nerve entrapment in the lumbar region, that it was the neurological problem which was the source of pain the plaintiff experienced at the time and that it was this condition which had to be treated for the relief of that pain.

Yekiso J stated that in the determination of whether the defendant took all reasonable steps in his examination of the plaintiff, it was appropriate to cite the remarks made in the introduction to the Medical Law Student Guide presented by Professors S A Strauss and M C Maré of the University of South Africa. Those remarks are to the following effect:

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

He said if one were to look at the number of guidelines regulating every facet of medical practice, from the initial consultation, medical examination, ethical and professional rules, guidelines for good practice, seeking patients' consent, one's

immediate reaction would be that the medical profession is one of the most over regulated professions in the world. But it is specifically because the medical profession deals with protecting man's life, personality, physical integrity, health and dignity that the medical profession appears to be the focus of constant search light. It is for reasons cited in those introductory remarks that the Health Profession's Council of South Africa, a statutory body regulating the medical profession, has issued various guidelines regulating good practice, ethical rules and professional self-development, which the medical profession is expected to adhere to. There is no certainty as to the legal status of these guidelines except to say they constitute general practice accepted in the medical profession.

The court observed that the plaintiff first consulted the defendant on Tuesday, 6 June 2000. The consultation could have taken place after 13h30 as the plaintiff had arranged to see the defendant at that time. According to the plaintiff, this was after he had handed over to the defendant a referral note given to him by Dr Simons a day before, being Monday, 5 June 2000. The defendant recalled having been handed Dr Simons's referral note by the plaintiff. He could not recall what the contents of the letter were except to specifically recall that there was reference in it to a "vascular" problem. Furthermore, the defendant could not recall what was said or discussed during such consultation except to say he would have followed a normal pattern during such a consultation. He would have made notes of such a consultation at the back of the admission form and, at a later stage, would have gone through the notes, dictated a formal letter containing all the information gathered during such a consultation to the referring general practitioner and keep such a letter as his notes. He would then keep the handwritten notes for a period of time and, according to his evidence, once the load of paper has built up, he would then dispose of such notes by destroying them for purposes of recycling. Whatever notes he may have made in his consultation with the Plaintiff, so did the defendant say in his evidence, he may either have destroyed or disposed of for recycling.

Yekiso J noted that the guidelines applicable to medical practitioners and dentists on keeping of patients' records, define a "medical record" as follows:

"A medical record is constituted by any record made by a medical practitioner at the time of or subsequent to a consultation with, an examination of, or the application of a medical or surgical procedure to his or her patient and which is relevant to thereto."

The notes referred to by the defendant fell squarely within the definition of a medical record in terms of this definition. Yekiso J observed that paragraph 4 of the guidelines under the heading "Compulsory Keeping of Records" provides that a medical practitioner shall, amongst other things, enter and maintain records relating to the assessment of the patient's condition and the proposed clinical management of the patient. Paragraph 6 of the guidelines provides that such records shall be stored for a period of not less than 6 years from the date they became dormant. The guidelines further provide that other personal records should be kept for a period of eight years after the conclusion of the treatment. The defendant did not have any record relating to the consultation he had with the plaintiff other than a reference to such a consultation in a letter addressed to Dr Simons dated 26 June 2000. He did not have a copy of Dr Simons's referral letter nor did Dr Simons have it in his file.

The defendant did recall, based on a letter addressed to Dr Simons dated 26 June 2000, that the plaintiff complained of pain on the outer part of the lower leg, just above the ankle; that his foot was painful; that the pain was severe for the past five days; that stepping on the foot made the pain worse. He recalled that the plaintiff informed him that he smokes 30 to 40 cigarettes a day. He suspected that the plaintiff had a vascular problem as he could not feel any pulses in the right leg, which, according to him, was abnormal. He did feel pulses in the left leg; he could not feel the right pulse at all so that he could not compare the two pulses. He recalled that the plaintiff was limping as he walked into the examination room and that he clearly was in pain.

According to the defendant's evidence, both as regards the initial consultation and the physical examination of the plaintiff, the enquiry during such consultation seems to have focussed on the plaintiff's professed vascular disease as the proximal cause of the pain the plaintiff experienced at the time. The court observed that this was not surprising in view of what the defendant did recall of a reference to a "vascular" problem in a referral letter addressed to him by Dr Simons. It noted that the defendant

directed no enquiry to the plaintiff as regards his ability to exercise, or his ability to perform the ordinary daily physical functions which would be expected of a normal healthy person. No enquiry was made as regards whether the plaintiff had a history of claudication or whether there was a particular incident linked to the cause of the plaintiff's complaint. When the defendant suggested to the plaintiff that the angiogram be performed it was with a view to establishing what the defendant referred to in his evidence as the "geography" of the plaintiff's arteries in the iliac system so as to obtain the appropriate sites for the location of the bypass prosthesis and not for purposes of diagnosing the extent of the plaintiff's blood flow in the right lower leg. After the angiogram had been performed the defendant performed surgery on the plaintiff the following day, Thursday, 8 June 2000.

Yekiso J noted that the defendant did not make contemporaneous handwritten notes when he consulted and physically examined the plaintiff and, if he did, as he claims to have done in his evidence, he had these destroyed shortly after he had despatched his letter dated 26 June 2000 to Dr Simons or such notes may have been disposed of for recycling. The only indication of the symptoms the plaintiff manifested shortly before the operation by the defendant was the handwritten notes by Dr Simons made during the consultation he had with the plaintiff on Monday, 5 June 2000. It was accepted by all the parties concerned that when the plaintiff consulted with the defendant on Tuesday, 6 June 2000, he manifested an extensive vascular disease which required surgical intervention. The issue to be determined, said Yekiso J was whether, on the probabilities, the vascular disease the plaintiff manifested at the time was the source of pain and discomfort the plaintiff experienced at the time and if so, whether it required urgent surgical intervention. The court observed that under cross-examination the defendant initially testified that after he had physically examined the plaintiff he had determined that the plaintiff's vascular disease needed urgent attention. This he said in an explanation as to why he had booked the theatre for an operation the following day, 8 June 2000. Asked why he was of the view that the disease needed urgent intervention he responded that his earlier reference to urgency was a mistake and all that he had meant to convey was that an attempt had to be made to assist the plaintiff as expediently as possible. In his letter to Dr Simons dated 26 June 2000 the defendant stated that the plaintiff's right foot was clearly "ischaemic" with blue discolouration and decreased temperature. He diagnosed a severe peripheral

"ischaemia". The defendant held this view despite the presence of sufficient collateral blood supply as is clearly evident in the angiographic images. Yekiso J said, in the absence of clear indication of lack of blood supply to the body extremities such as the right foot in the instance of this matter, he could not see how the defendant could determine that the source of pain and discomfort that the plaintiff experienced at the time of his examination could be of severe peripheral ischaemic origin requiring urgent surgical intervention. Yekiso J observed that the defendant omitted to enquire into the plaintiff's ability to exercise. He failed to establish if the plaintiff's complaint was linked to any particular incident; the symptoms the plaintiff manifested at the time were suggestive of a neuralgic disease; he failed to diagnose the neuralgic disease when symptoms suggestive of "sciatica" were glaring; he failed to inform the plaintiff that the vascular operation was not urgent; that the plaintiff could undergo vascular surgery at a later stage probably when he could afford the procedure of his preference; he failed to keep contemporaneous notes when consulting and examining the plaintiff. The cumulative effect, said Yekiso J, of all these factors justified no other conclusion other than that the standard adopted by the defendant did not measure to the reasonable standard expected of a man of his calling.

Whether the plaintiff consented to the procedure performed, was the next issue to be determined. In this regard Yekiso J made the following observations. For a medical practitioner to be able to invoke a patient's consent as a ground of justification, it must be shown that the patient not only consented to the injury and the medical intervention proposed, but that the patient also consented to the risks and consequences consequent upon such medical intervention. Consent will therefore only be valid where it is based on essential knowledge regarding the nature and the effect of the proposed treatment. This entails that consent must be informed. Consent to treatment will only be "informed" if it is based on substantial knowledge concerning the nature and the effect of the act consented to. Thus a medical practitioner is obliged to warn a patient of the material risks and consequences which may ensue during and consequent to the proposed treatment. In *Castell v De Greef*, Ackerman J formulated the following test in the determination of whether or not consent has been given in any set of circumstances and whether such consent is informed:

"For consent to operate as a defence, the following requirements must, inter alia, be satisfied:

a) the consenting party must have had knowledge and been aware of the nature of the harm or risk;
b) the consenting party must have appreciated and understood the nature and extent of the harm and risk;
c) the consenting party must have consented to the harm and assumed risk;
d) the consent must be comprehensive, that it extend to the entire transaction, inclusive of its consequences."

There is a duty on the medical practitioner properly to inform the patient of the risks attendant on his or her treatment and its dangers. The object is to enable the patient to decide whether or not to run the risk of consenting to the treatment or procedure proposed (see *Chester v Afshan*[146]). In *Richter and Another v Estate Hamman*[147] the court held that a doctor's conduct in informing a patient of the material risks attendant to the proposed treatment or procedure should be adjudged by the standard of the reasonable medical practitioner faced with a problem concerned. The court postulated this approach as follows-

"In reaching a conclusion (as regards the disclosure of a risk by the doctor) a court should be guided by medical opinion as to what a reasonable doctor, having regard to all, the circumstances of the particular case, should or should not do. The court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence,"

Yekiso J noted that the full bench in *Castell v De Greef* did not follow the approach in *Richter*. It held that a medical practitioner is obliged to warn the patient consenting to a medical treatment of a material risk inherent in the proposed treatment holding that "a risk is material if, in the circumstances of a particular case:

a) a reasonable person, in the patient's position, if warned of the risk, would be likely to attach significance to it or
b) the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."

This standard which, in the view of Yekiso J, and as was indeed held in *Castell v De Greef*, focuses on patient autonomy rather than the views of the medical profession, is in conformity with the fundamental right of individual autonomy and self-determination. He found that he was thus bound to follow this approach unless satisfied it is clearly wrong, which it is not. The question, said Yekiso J, as to whether or not consent was given in any set of circumstances is one of fact. The law does not,

146 *Chester* (2002) 3 All ER 552 at 572E
147 *Richter* 1976(3) SA 226(C)

save in certain specific instances, prescribe how the required consent should be procured. Based on this approach he proceeded to determine, on basis of evidence, if the consent purportedly procured from the plaintiff was an informed one.

It appeared from the evidence that arising from a consultation and the subsequent examination of the plaintiff, the latter was offered the aorta-bifemoral procedure to address his problem. This offer, was subject to an angiogram being performed on the plaintiff which was done on Wednesday, 7 June 2000. Shortly after the angiogram was performed, the plaintiff was admitted to the ward. According to the plaintiff's evidence no further discussion took place after the angiogram was performed until the early evening when the defendant was called into the ward and the discussion of the cost implications of the proposed treatment ensued. It also appears that a Mrs Cloete, who was in the employ of Panorama at the time, was present when the discussion took place. The plaintiff stated in his evidence that it was not clear to him what was being discussed in this discussion except to say only one procedure was suggested to him. Nothing was said to him, according to his evidence, about the precise nature of the procedure suggested or any material risks attendant on the procedure proposed.

When the defendant was asked when the plaintiff's informed consent was obtained to the procedure performed the defendant replied that as far as he could recall, the required consent was obtained in the evening of Wednesday, 7 June 2000 after a lengthy discussion about the cost implications. When further asked if the consent was obtained on Wednesday evening in the ward, the defendant's response was that he was not certain, that it could have been in the evening or it could have been the next morning, that is the morning before the operation. It either could have been late in the evening of Wednesday, 7 June 2000 or the following morning, so the defendant said. The defendant stated further that the required consent was discussed with the plaintiff verbally and once consent was given the patient would sign a form. The defendant was then referred to the form the plaintiff signed in the morning of 8 June 2000 and asked if that is the consent form relied on and the defendant replied in the affirmative. The defendant stated in evidence that the procedure performed on the plaintiff was ilio-femoral by-pass operation but, on basis of the consent form, the plaintiff consented to a femoro-femoral by-pass operation. Yekiso J noted that the defendant further stated in his evidence that the procedure required to be performed on the

plaintiff was not urgent despite the fact that the plaintiff experienced severe pain at the time. There was no evidence to suggest that the defendant did discuss this lack of urgency or that the procedure could be performed at a later stage in order for the plaintiff to decide when it would be appropriate and convenient for him to undergo the proposed operation.

The plaintiff's version was that in the discussion he had with the defendant, in the presence of Mrs Cloete, only one procedure was suggested to him and no other procedure was discussed with him other than the one the defendant offered. Yekiso J observed that if consent to the alternative procedure was offered and accepted in this discussion, it would have been accepted and, therefore, procured in the presence of Mrs Cloete. Mrs Cloete who could have corroborated the defendant's version was not called to testify nor was she amenable to be subpoenaed by the plaintiff. The judge said that the inference was thus irresistible that either her evidence would have supported the plaintiff's version or would not have supported the defendant's version. But if she would have supported the defendant's version it was inconceivable why she was not called. Yekiso J found that on the evidence he could not find that the plaintiff was properly counselled before the vascular operation was performed, that other options, other than the procedure performed, were properly discussed with him, in particular that he did not need to undergo the vascular operation immediately, that he was advised of the material risks attendant to such operation and that he had given an informed consent to such operation. He then turned to the question of whether the defendant's failure to obtain the informed consent of the plaintiff amounted to an assault. In this regard Yekiso J noted that in a number of decisions the courts have always held that in instances where a medical practitioner administers treatment to a patient without the patient's informed consent, such conduct constitutes assault[148]. The judge then noted that there is a school of thought that such conduct on the part of a medical practitioner, if it falls short of assault, it nonetheless could amount to a violation of a right to privacy. The court noted that in *Broude v McIntosh & Others*[149] Marais JA considered it a strange notion that this type of conduct should be juristically characterised as an assault. He made the following remarks:

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148 He referred specifically to *Esterhuisen v Administrator, Transvaal* 1957(3) SA 710(T), *Lampert v Hefer N.O.* 1955 (2) SA 507(A) and *Stoffberg v Elliot* 1923 CPD 148

149 *Broude* 1998(3) SA 60 (SCA)

"Pleading a cause of action such as this as an assault to which the plaintiff did not give informed consent is of course a familiar and time-honoured method of doing so. However, I venture to suggest with respect that its conceptual soundness is open to serious question and merits re-consideration by this Court when an appropriate case arises."

It was the view of Yekiso J that these remarks were no more than an *obiter dictum* so that, bound as he was by the ratio of the Full Bench of the Cape High Court in *Castell v De Greef* he therefore found that the defendant's conduct, to the extent that whatever consent which may have been given was not properly informed, constituted assault.

Yekiso J observed that Prof De Villiers ascribed the plaintiff's current state of claudication to a "steal syndrome" caused by the diversion of blood flow from the donor limb to the diseased limb, that this "steal phenomenon" is an inherent risk to the type of operation the defendant performed on the plaintiff and that this complication should have been anticipated irrespective of whether there is a proximal or distal stenosis. The view held by the defendant and his experts was simply that if the take-off site of the graft was located on or below a proximal stenosis, it would have no effect on the donor limb, and in view thereof, no diversion of blood flow will ensue. This contention caused the court great difficulty. In the first instance, the very procedure which the defendant claimed to have performed was in itself in dispute.

The consent form signed by the plaintiff indicated that the plaintiff consented to a *femoro-femoral* by-pass operation. The defendant, on the other hand, contended he had performed an *ilio-femoral* by-pass operation. No operation notes were either produced or discovered to verify the kind of procedure the defendant performed on the plaintiff. The court observed that there was a significant difference between the two operations although both were classified or fell into the category of so-called "cross-over" operations, the point of departure being that the graft was at differing places, with the ilio-femoral being performed higher up than the femoro-femoral procedure. It was therefore difficult, said Yekiso J, to uphold the defendant's contention without, in the first instance, being in the position to determine which procedure was performed. The defendant was assisted by Dr Charl Dreyer. According to the defendant Dr Dreyer would have been in a position to testify as to the take-off

site of the graft on the left leg and also confirm the type of operation performed. But Dr Dreyer was not called to give evidence on behalf of the defendant. Yekiso J noted that claudication, according to *The World Book Medical Encyclopaedia: Your Guide to Good Health*, is limping that is usually caused by pain. Intermittent claudication, which was the symptom the plaintiff was experiencing, is pain or cramp in the calf muscle after exercise. It is relieved by rest, but the pain recurs when the muscle is again exercised. The cramp like pain is the result of inadequate blood supply with the resultant inadequate amount of oxygen to the calf muscle. The plaintiff contended that he did not experience this symptom prior to an operation and that this symptom only manifested immediately he had undergone vascular surgery.

There was a further difference of opinion amongst experts as regards the cause of the plaintiff's current symptoms, Prof De Villiers holding the view that the plaintiff 's current symptoms were as a direct result of the vascular surgery performed on the plaintiff by the defendant. Prof de Villiers postulated the position as follows in his evidence:

"...there is less blood supply to the left leg and therefore you get claudication. So in that respect, in respect of the operation done by Dr Louwrens, in that respect he is responsible for it."

In support of this view Prof de Villiers relied on the view expressed in a recent publication *Vascular Surgery*[150]. The passage relied upon read as follows:

"It is possible to produce steal in the donor extremity after femoro femoral bypass if there is outflow occlusive disease (eg. Superficial femoral artery occlusion) on the *donor* side. Even if this is not likely to become clinically manifest, however, unless there is greater flow demand (eg. with exercise), donor iliac artery stenosis or poor cardiac function."

Dr de Kock, whose view was supported by the defendant and as well as the defendant's other experts said the following in his expert summary:

"When after femoro-femoral bypass procedure, the blood supply to his right leg was significantly improved, he became more mobile as a result of which he developed claudication in the left leg and possibly exerted himself to the extent where he suffered a disc prolapse."

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150 Rutherford RB (5th ed) at p 983

Dr de Kock was further of the view that, because the plaintiff had an occlusion of the left superficial femoral artery and relying on the angiographic images of the plaintiff's blood supply, there is no way that the plaintiff could have been active enough prior to undergoing surgery to precipitate symptoms of claudication.

Prof De Villiers stated in his evidence that the risk of steal arising following an ilio-femoral or femoro-femoral by-pass operation is in the order of 15%. In support of this contention he referred to a clinical study of war veterans, the Veterans Administrative Co-operative Study and the Veterans Administration Hospitals. In this study, so Prof de Villiers testified, three hundred and seventeen patients who had femoro-femoral by-pass surgery were examined for post-operative vascular changes that developed in the donor limb. Unmasked claudication developed in 7%; new claudication related to steal developed in 3,5%; prognosis of pre-operative claudication developed in 1,7% and concluded that the donor limb pressure measurements post-operatively is in the order of 15%. Yekiso J stated that in his view the opinion expressed by Professor de Villiers was based on logical reasoning, had a logical basis, accorded with the objective evidence and was capable of logical support. He was further of the view that the symptoms of claudication the plaintiff was experiencing were as a consequence of the vascular operation performed by the defendant, that the plaintiff's current symptoms were an inherent risk of a significant nature and that the defendant failed to inform the plaintiff of this risk adequately or at all.

Yekiso J concluded that the defendant, in his consultation and pre-operative advice to the plaintiff, acted in breach of his contractual obligations in the respects set out in paragraph 6 of plaintiff's particulars of claim and, in particular, the defendant failed to procure the plaintiff's informed consent in respect of the operation performed on the plaintiff and, in absence of consent which is properly informed, the defendant's conduct constituted assault. In the light of this finding, he said, it was not necessary to determine the issue of misrepresentation alleged in paragraph 7 of the plaintiff's particulars of claim.

He found that as a result of the defendant's breach of his contractual obligations, the plaintiff suffered damages as more fully set out in paragraph 9 of the plaintiff's particulars of claim the extent and quantum of which, *per* agreement between the

parties, was still to be determined and which damages were as a result of failure by the defendant to discharge his contractual obligations. Consequently Yekiso J ruled that the defendant acted in breach of his contractual obligations arising from the oral agreement entered into between the plaintiff and the defendant on 6 June 2000 and ordered the defendant to pay the plaintiff's costs on a party and party scale, such costs to include the qualifying expenses of the expert witnesses.

Discussion

It is submitted that the decision in this case is an exemplary one that clearly illustrates a number of the points that have been made earlier in this chapter. Unlike the decision in *Afrox Healthcare v Strydom*, the court in this case had no difficulty in recognising the contextual differences between contracts involving provider and patient and those involving providers and users of other kinds of services. Yekiso J expressly referred to the fact that the medical profession deals with protecting man's life, personality, physical integrity, health and dignity that it is precisely for this reason the medical profession is the focus of a constant search light and appears to be one of the most over regulated professions in the world. The facts of the case indicate the lack of regard in which medical practitioners in South Africa hold their patients, their inattention to the complaints of patients and their failure to adequately monitor and evaluate the patient's condition before and after treatment. One might not unreasonably describe the attitude manifested by the medical practitioner on the facts of the present case as a lack of regard for the human dignity of the patient. He apparently did not inform him of the true nature of the operation to be performed on him, he did not take sufficiently seriously the patient's complaints of continued pain despite the treatment administered, treatment alternatives where not discussed with him, the circumstances in which the patient's consent was sought were clearly unimportant to the medical practitioner treating him and the risks attendant upon the proposed surgical procedure were not explained. It is submitted with respect that Yekiso J's view that such handling of a patient could in certain circumstances constitute assault and his refusal, whether for reasons of precedent or not, to take up the suggestion which the court seemed to have raised in *Broude v McIntosh &*

Others[151] that failure to obtain informed consent should not be regarded as assault is laudable and entirely consistent with the importance of the constitutional right to human dignity and the fact that dignity is a fundamental value upon which the Constitution is based. It is submitted that it is necessary and appropriate both in light of the current climate of health services delivery in South Africa, as evidenced by the manner in which the plaintiff in the present case was handled by the defendant, and in view of the manner in which the medical profession in South Africa has in the not so distant past condoned or overlooked violations of the right to bodily and psychological integrity, to continue to label medical treatment in the absence of informed consent as assault. Such a label aptly conveys the gravity of the failure to obtain such consent and the level of public disapproval of such failure in terms of the legal convictions of the community.

The court's censure of the defendant for his failure to keep proper medical records is also worth noting. Failure to keep proper medical records not only acts to the detriment of a health professional when he or she has to defend claims of breach of contract or medical negligence but also impairs his or her ability to adequately treat a patient since there is no record of the patient's complaints, what was or was not done to address them and the extent to which treatment was effective. When coupled with the health practitioner's obvious inability in this case to remember even important details such as the nature of the operation that was in fact performed and whether or not the informed consent of the patient to that particular operation was obtained, this suggests a potentially irrational and piecemeal basis for the treatment of a patient that falls far below the standard of care required of a person holding himself out as an expert and a professional. If a medical doctor cannot remember from visit to the next the nature of the treatment administered to a patient, and does not record such details how can he possibly claim to be treating the patient with due care and skill? Many health conditions are ongoing as for instance in the case of chronic conditions. Patients develop immunity or become resistant to certain treatments over time so that they become ineffectual necessitating a variation in the treatment regime. Some treatments are unsuccessful for certain patients whilst successful for others which means there may be a treatment list that one has to work through to establish what

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151 *Broude v McIntosh and Others* fn 149 *supra*

works for a particular by process of elimination. Other treatments are only effective in the absence or presence of certain medication, certain allergies, certain socio-economic factors etc while still others preclude the possibility of subsequent administration of alternatives. If a provider of health care services does not recall the nature and extent of previous treatments he has administered to a patient, this can have potentially serious consequences for that patient which is no doubt why proper record keeping is an ethical and professional requirement. The failure to keep a proper patient record could, in its own right constitute professional negligence in certain circumstances. In the present case the defendant could not apparently even prove conclusively the exact nature of the operation that he had performed on the patient. In the context of a claim for medical negligence it would be extremely difficult to show that he acted reasonably in doing the operation that he in fact performed.

6.3 Summary and Conclusions

The law of contract as it is currently interpreted and applied by the courts does not take cognisance of certain practical realities in the context of health services delivery. It is most unfortunate that the Supreme Court of Appeal has persisted in regarding health care services in the same light as any other service and suppliers of health care services the same as suppliers of any other service. The writer has made the point elsewhere, but it bears repeating here, that the law is only relevant in context. If law is to be meaningful the context in which it is applied must inform and if needs be modify the broad general principles in order to ensure that justice is done. To elevate legal principles above the need for justice and above the precepts of public policy as evidence within the Constitution is to diminish the value of law to society. The law of contract should not be construed or applied in the same way that it was one hundred years ago because although legal precedents evolve slowly, the context in which they must be applied has changed drastically. New developments in the funding and delivery of health care services, different ways in which relationships between provider and patient have come to be structured, the profound changes to the South African legal system wrought by the Constitution, and more specifically in the present context the fact that access to health care services is now a constitutional right have all contributed significantly to a very different 'commercial' context for the delivery

of health care services. There is widespread international recognition of the need to protect consumers from unconscionable, unfair clauses in contracts. There is also considerable international debate and discussion concerning contract theory and the directions in which the law of contract, and indeed the concept of contract, needs to evolve in order to remain meaningful to society [152]. It is fairly obvious to anyone prepared to devote even a little thought to the subject of contracts and the environment in which they operate to appreciate that the world has changed

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152 See generally Harker, 'The role of contract and the object of remedies for breach of contract in contemporary Western society' 1984 *SALJ* 121; Hillman, R A 'The Crisis in Modern Contract Theory' 67 *Texas Law Review* (1998) p 103; Macneil I, "Contracts: Adjustment of Long-Term Economic Relations Under Classical, Neoclassical and Relational Contract Law'72 *Northwestern University Law Review* 1 p 19.
Heffey P, Paterson J and Robertson A *Principles of Contract Law* point out that recent research on contracts "shows that parties to commercial contracts are not the hard-bargaining individuals engaged in discrete, one-off transactions that classical contract theory and neo- classical economics would have us believe. Parties to contracts are often engaged in long-term relationships with one another, or as part of a close-knit industry, and that has a significant impact on the way in which they deal with one another. These empirical insights have given rise to a whole new way of looking at contracts. Rather then viewing contracts as discrete exchanges between utility-maximising individuals, relational contract theory views contract as a more complex social interaction. Macaulay identified the need to view contracts in a different way which took into account the relations between the parties. Ian Mcneil then explore what it mean to look at a contract from a relational perspective." They observe that Mcneil's analysis of contracts is based on recognition of the fact that contractual relations are conducted within a social matrix. Exchange is only possible within a society that provides: firstly a means of communication (so that the parties can understand one another) secondly: a system of order so that the parties use exchange rather than force to get what they want); thirdly, a payment mechanism for the enforcement of promises. Since a contract can only be made against such a social background, all contracts are relational, in the sense of involving social relations and being embedded in a much broader social web. Some contracts are, however, more relational than others in the sense that they are more deeply embedded in social relations. Mcneil has suggested that there exists a spectrum of contractual behaviour with highly relational contracts at one end and discrete transactions at the other. A relational contract is one in which social relations play a significant role. This may be because the performance of the contract is so closely integrated with the parties' other activities, because parties are relying heavily on social conventions or because the parties are involved in a long-term relationship. In a highly relational contract the parties are less likely to be able to predict and deal with future contingencies. The more relational the exchange, the less the parties will plan and allocate risks. Thus more flexibility will be required during the course of the relationship…Social relations may play a significant role in an exchange because the parties expect each other to behave in accordance with social customs and conventions which define their respective roles. The role of a medical doctor for example, is defined by social convention. A patient consulting a doctor about a particular medical problem would find it very difficult to spell out in advance the doctor's obligations in respect of diagnosis, treatment and referral. Instead of attempting to define the doctor's obligations in advance, the patient relies on the doctor to operate within and fulfil the doctor's socially understood role."
It is submitted that where the role of the doctor as socially understood, has in fact departed from that social understanding, for example with regard to the fiduciary relationship of a doctor to a patient where the doctor himself no longer considers the relationship to be fiduciary, this is evidence of a need for the legislative, judicial or regulatory protection of the patient. The arguments of the patient in Afrox (fn 100 *supra*) in terms of his perceptions of the manner in which a private hospital is supposed to behave towards its patients as opposed to the approach of the hospital itself to its patients is a case in point. The patient had a relational perception of his contract with the hospital whereas the hospital itself perceived the transaction as discrete and structured it that way. It is submitted that to permit contracts structured on the basis of discrete transactions that more appropriately belong in the relational setting, as the court did in *Afrox*, can lead to the unfair application of the rules of the law of contract and an unacceptable disregard for clear principles of public policy.
Heffey *et al* note that: "At the discrete end of the contractual spectrum are transactions that are more isolated from the social context in which they are made. A relatively discrete transaction does not involve any significant co-ordination between performance of the contract and the parties' other activities, requires less flexibility and co-operation between the parties and does not draw so heavily on social conventions and understandings. A one-off exchange will usually be relatively discrete, but this will not always be the case. A single visit to a doctor is likely to be highly relational, for the reasons discussed above, even if the patient has not seen the doctor before and never does again. Mcneil's example of a highly discrete transaction is a motorist making a cash purchase of petrol at a service station on a highway on which the motorist rarely travels. This transaction involves the simultaneous (or almost simultaneous) exchange of goods and money, and does not involve any ongoing obligations. Even this transaction is deeply embedded in a broad, complex social web consisting of such things as social conventions regarding behaviour, brand loyalty (possibly involving loyalty reward schemes) and credit card or electronic payment mechanisms." The authors point out that the relational perspective identifies a deficiency in classical and economic approaches to contract law because the discrete exchange is at the heart of both understandings of a contract. They note that Gudel ('Relational Contract Theory and the Concept of Exchange') (1998) 46 *Buffalo Law Review* p 763) has observed: "Contract law was and is relatively well adapted to dealing with discrete transactions. However, it was and is ill-equipped to deal with problems arising out of contract relations. To put it another way, contract law has had a powerful bias in favour of dicreteness, and discrete legal doctrines applied to relational contracts often produced results that were intuitively unfair."

considerably since Roman times and that contracts are instruments used to regulate highly complex, socio-economic, as opposed to purely economic, relationships between parties. The interests of broader society in contracts between two parties have intensified in many instances to the point where legislation governs the standard terms and dictates whether or not terms introduced by the parties themselves are socially and legally acceptable. Fuller and Perdue[153] observe that the proposition that legal rules can be understood only with reference to the purposes they serve would today scarcely be regarded as an exciting truth. The notion that law exists as a means to an end has been commonplace for at least half a century. They point out, however, that there is no justification for assuming that because this attitude has now achieved respectability, and even triteness, that it enjoys a pervasive application in practice. We are still all too willing, they say, to embrace the conceit that it is possible to manipulate legal concepts without the orientation which comes from the simple inquiry: toward what end is this activity directed? It is submitted that nowhere in South African law is the truth of this statement more evident than in the judgment of the Supreme Court of Appeal in *Afrox Healthcare v Strydom*[154]. Relational contract theory contests the idea that promise is at the heart of contract. In more relational exchanges, since the parties do not plan in a comprehensive way, their promises are likely to be incomplete (which is exactly the case in most health care settings) and so their association will be governed by relational norms[155].

In the context of health care services in particular, the contractual relationship, as opposed to the delictual one is problematic in South African law. The law of contract does not recognise damages for non-patrimonial loss and yet does not satisfactorily

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153 Fuller L L and Perdue W R (Jr) 'The Reliance Interest in Contract Damages' *Yale Law Journal*, http://www.bepress.com/ils/iss1/

154 *Afrox* fn 100 *supra*

155 Hillman, 'The Crisis in Modern Contract Theory' 1998 67 *Texas Law Review* 103 as referred to by Heffey, Paterson and Robertson (fn 152 *supra*). See also Kraus J 'The Methodological Commitments of Contemporary Contract Theory' University of Virginia School of Law, Law and Economic Research Paper Series Working Paper No. 01-2 May 2001 http://papers.ssrn.com/ ; Schwartz A and Scott RE 'Contract Theory and The Limits of Contract Law'. These two authors observe that contract law has neither a complete descriptive theory, explaining the law that is, nor a complete normative theory, explaining the law that should be. They say that these gaps are unsurprising given the traditional definition of contract as embracing all promises that the law will enforce. "Even a theory of contract law that focuses only on the enforcement of bargains must still consider the entire continuum from standard from contracts between firms and consumers to commercial contracts between business firms. No descriptive theory has yet explained a law of contract that comprehends such a broad domain. Normative theories that are grounded in a single norm – such as autonomy or efficiency – also have foundered over the heterogeneity of contractual contexts to which the theory is toapply. Pluralist theories attempt to respond to the difficulty that unitary normative theories pose by urging courts to pursue efficiency, fairness, good faith and the protection of individual autonomy. Such theories need, but so far lack a meta principle that tells which of these goals should be decisive when they conflict."
http://www.utexas.edu/law/news/collquium/papers/Schwatrzpaper.pdf

address the question of why exactly the risk of these damages should, in the case of a contract for health care services, lie with the patient rather than the provider of such services. The risk of pain and suffering is integral, rather than incidental, to the services contemplated in a health care contract. It has been noted that the South African courts seem to have a preference for dealing with claims involving health care services on delictual rather than contractual grounds where both are an option. It is submitted that one of the reasons why the delictual relationship possibly lends itself more readily to resolution of a case is because it is more expressly contextualised within the society in which it operates with concepts such as unlawfulness being overtly decided with reference to public policy and the legal convictions of the community and with no possibility of the exclusion of these factors by means of a condition agreed between the parties as would be the case in the contractual setting. The 'commercial' flavour of the law of contract in South Africa does not sit comfortably in the context of health services delivery since considerations involving bargains and bargaining power, the relative autonomy of the contracting parties to dictate the terms of the contract and the importance of freedom of contract are not central issues when it comes to access to health service delivery.

In the context of the public health sector, the notion of a contractual relationship between provider and patient is seldom if ever essential to the delivery of health care services. Regulations determine the fees payable by the patient and public policy and public health planning determine the range of health services available to the patient and the circumstances in which they may be accessed. Within the private sector, the notion of a contract between provider and patient seems to be relatively more important in the sense that it gives the provider a legal right to claim payment from the patient but in reality, the majority of patients cannot afford the costs of medical treatment, especially in private hospitals, in the absence of funding by a third party such as a medical scheme. The promise of recovery of payment from a patient through the enforcement of contractual obligations in the event of the failure of a medical scheme to pay is often hollow and for the provider, represents the risk of a bad debt. Then there is the other socio-economic aspect which involves the attachment by a provider of major assets of the patient such as a house or a car in order to recover payment on the debt owed by a patient who, often through no fault of his own, is left in the lurch by a medical scheme or insurance company when both he

and the hospital were under the impression at the time of treatment, that the funds therefor were available. Is it really in accordance with constitutional principles, rights and values that a person must sacrifice one socio-economic right (such as the right to housing or shelter) in order to be able to exercise another (the right of access to health care services)?

It is clear that unless South African courts are prepared to depart from antiquated views of the contexts in which the law of contract operates and to accept modern socio-economic and relational realities, the law of contract in the health sector at least, has a very limited future as between provider and patient. Contracts between corporate funders of health care services and providers of those services may serve to largely replace the need for contracts between the individual patient and the provider in many instances as the South African government is presently considering a system of Social Health Insurance which will operate as much within the private sector as in the public sector. Legislation tends increasingly to govern relationships between providers and patients in such environments. The beginnings of such legislation, in the form of the provisions of the Medicines and Related Substances Act[156] concerning the licensing of dispensing doctors and the pricing of medicines are concrete examples of such a trend. More advanced approaches to the law of contract clearly indicate that contracts still have much to offer in the regulation of relationships between private individuals and entities even in the context of health service delivery. If the South African law of contract was capable of embracing such advanced approaches and developing in a way that effectively and realistically meets the needs of South African society there is no doubt that it could still be a useful way of understanding and upholding various kinds of relationships in civil law. Unfortunately there seems to be little promise of such developments locally.

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156 Fn 12 *supra*