Chapter 8

Law of Delict In Health Service Delivery - Public Sector

8.1 Introduction

The principles of the law of delict do not differ between the public and the private sectors. However because the private sector and the public sector tend to have certain operational differences with regard to the manner in which they render health care services, in practice there will be different emphases placed on different aspects of the law of delict discussed above within the different sectors. Vicarious liability, for example, is of much greater interest to the public sector than the private sector in terms of the risks it poses simply because the public sector employs more kinds of health professionals than does the private sector. The public sector is concerned with the public demand for health care services in a quite different way to the private sector and legal issues involving the rationing of health care services, for instance, are much more likely to be an issue in the public sector than in the private sector. In the public sector, by contrast, competitive issues are not nearly as significant as they are in the private sector although the sharp divide that once existed between these two sectors in terms of their respective 'turf' is becoming less distinct in that changes to medical schemes legislation allow for the designation by medical schemes of public health facilities as preferred providers and some public hospitals are actively targeting as patients medical scheme members who in the

not too distance past would have been the preserve of the private provider sector until they ran out of medical scheme benefits.

These features and other operational differences between the public and private health sectors will become evident from closer examination of the case law involving the two different sectors. This chapter focuses on the case law involving the public sector whilst chapter nine focuses on the case law involving the private sector. For a general discussion of fundamental principles of the law of delict as they relate to health service delivery, see chapter seven of this thesis. An examination of the relevant case law is important because it gives a sense of the manner in which the fundamental principles of the law of delict, discussed in chapter seven, are applied in practice. Since the law does not operate in a vacuum, a comprehensive consideration of the case law is essential to an understanding of the law of delict as it relates to health service delivery. Such a consideration also serves to highlight the extent of the progress that has been made by the courts in 'constitutionalising' the law of delict in this field.

8.2 Case Law

8.2.1 *Rex v Van Schoor* [1]

Facts

The accused was charged on two counts of culpable homicide, in that on the 9th February, 1948, he wrongfully, unlawfully and negligently administered a lethal dose of a certain arsenical preparation known as Neo-Halarsine to each of two patients, Simon Mtoa and Trollie Mandunda. They died from the effects of the preparation. The defence set up on his behalf was that in the circumstances under which the lethal doses were administered there was not that degree of

---

[1] *Van Schoor* 1948 (4) SA 349 (C)

negligence requisite to justify a finding that he had committed the crime of culpable homicide.

In the present case a young doctor was required to administer a dangerous poisonous drug to syphilitic patients. He had no experience in connection with the drug, so that he had to act with caution. He had arrived at Upington on the 2nd February to be Dr. Reitz's assistant, and on the 9th February, having had no experience in the administration of Neo-Halarsine, he treated a number of syphilitic patients, including the two deceased. When he was at the surgery where Dr. Eksteen, another assistant of Dr. Reitz, was dealing with other patients a number of syphilitic patients arrived and were awaiting attention at the clinic, thirty yards away. The time came for their treatment and Dr. Eksteen, who had intended to deal with them, was still busy. He therefore delegated the duty to the accused. The accused admitted that he had never in the past administered Neo-Halarsine, and though he stated that he had read a certain amount about the drug, it was clear from his evidence that his knowledge was scanty. When called upon by Dr. Eksteen to proceed with the treatment of the patients he apparently asked him how he should set about it. Dr. Eksteen, not realising the limited knowledge of the accused about the use of this drug, simply pointed to a shelf where this drug and other compounds were kept and said:

"Take an ampoule and mix it with 9 c.c. of water, and that would be the maximum dose".

Neo-Halarsine was kept in ampoules in carton boxes each box containing on the outside in a number of places a description of the compound and the dosage in the ampoule. Inside there were instructions as to how the compound had to be administered. The accused took from the shelf a number of cartons and proceeded to the clinic to administer the doses as contained in each ampoule to each of the patients, the administration being by way of intravenous injections. When Dr. Eksteen gave the instructions in the manner that he did, he was under

the impression that these ampoules contained .09 grams, but without his knowledge other cartons had been placed on that shelf containing ten times the quantity in each ampoule. When the accused took the cartons of compound out he could have seen, just by an ordinary glance, that they were multi-doses. He did not take the precaution to look and see that they were multi-dose. He also failed to read the instructions inside and he admitted that all these drugs were always accompanied by instructions as to the manner of use. In this manner the patients received doses ten times stronger than they should have received. The doses were administered with two fatal results. He apparently noticed that the ampoules contained 0.9 grammes of the compound, and when he was asked by the Court why he accepted that 0.9 gramme doses were the proper doses he merely stated that all the other preparations he had used in the treatment of syphilitic patients were of 0.9 dosage and he assumed that in the administration of Neo-Halarsine it would be the same. In the opinion of the court the accused was not justified in such assumption. The court said that he should not have relied on the very scanty knowledge that he possessed of such a dangerous drug without satisfying himself that he could safely administer a dosage of 0.9 gramme strength. It noted that if he had read the instructions he would have seen what was required of him. If, furthermore, he had been in doubt, he could have taken the ampoule, walked to Dr. Eksteen and consulted him further as the latter was only thirty yards away. The accused failed to do this. Under the circumstances, held the court, the accused did not exercise that degree of care in administering a poisonous drug as was required of a reasonable man, and in the circumstances found the accused guilty of the crime with which he had been charged.

Judgment

Both counsel for the Crown and counsel for the defence submitted that the test of what conduct constitutes negligence is the same in a criminal as it is in a civil case. With this the court agreed, but added that in a criminal case the Crown

must discharge the onus of proving the averred negligence beyond a reasonable doubt, whereas in a civil case a plaintiff discharges such onus if he succeeds on the balance of probabilities as to the facts of the case. The court added that it must not be forgotten that as to liability there are no degrees of negligence, whether the case is criminal or civil.

It stated that a person is either negligent or he is not, and that negligence is the failure to exercise the requisite care required of a reasonable man in all circumstances of each particular case. In the case of a person required to do the work on an expert, for example, a doctor dealing with the life or death of his patient, the court said that he too must conform to the acts of a reasonable man, but the reasonable man as viewed in the light of an expert.

The court made the point that even an expert doctor, in the treatment of his patients, would be required to exercise in certain circumstances a greater degree of care and caution than in other circumstances. For instance, in the treatment of patients, where he is dealing with a dangerous drug or medicine, as in the present case, administering a compound containing arsenic, he would be required to exercise far greater care than in the administration of a drug not containing such a poisonous or dangerous ingredient, and not only the administration of the drug but also the manner in which that administration is made may necessitate a different degree of care. Thus, if a poisonous compound is administered through the mouth to go straight into the stomach, its expulsion from the patient's stomach if discovered to be harmful would be relatively simple as compared with the difficulty attendant upon cleansing or purifying the patient's system if the harmful compound had been injected into the patient's veins. In the latter case, therefore, greater care must be exercised against the administration of an overdose. The court observed that it is thus very difficult to further particularise a standard of care. Each case depends on its own particular circumstances.

The court commented that the question of sentence was a difficult matter as the accused was a young man on the threshold of his career. It said that in imposing a punishment it was taking into consideration all the mitigating factors which the counsel for the accused placed before the Court. The court was impressed by the candid manner in which the accused gave his evidence and also by the argument that in this particular case the accused was to some extent the victim of circumstances. It noted that as soon as he discovered his mistake he did what he could for the patients and he withheld nothing from his principals. If it had not been that on this particular day Dr. Eksteen had been so busy, accused would not have been required to deal with these patients. The court also took into consideration the mental anxieties which the accused endured and the prejudice that he would suffer in his profession. It noted that the conviction might count against him in obtaining particular posts where the conviction by itself would be very damaging. It observed that there was also a possibility that the Medical Council may take steps against him and expressed the hope that the conviction and the sentence which it intended to impose would be regarded by the Medical Council as sufficient punishment. The lightest sentence the court felt it could impose was a fine of £10 on each count, or an alternative of fourteen days' imprisonment with hard labour on each count.

Discussion

This case although not expressly so is an illustration of the rationale behind the maxim *imperitia culpae adnumeratur*. The court refused to take into account the fact that the defendant doctor was newly qualified and not acquainted with the drug. He should at least have been able to comprehend the risks posed by his lack of knowledge of which he was clearly conscious at the time when he administered the drug since he had made enquiries from the more experienced doctor working nearby. Furthermore he made no attempt to read the labelling on the medicine which was there for the very purpose of informing users of the correct dosage and other important information. If one professes a skill then one

is judged by the standard of the reasonable person who also professes that skill. The standard is an objective and not subjective. It does not takes into account the lack of knowledge and experience of the particular practitioner concerned but looks rather at the knowledge and standard of care that one could reasonably expect from a person in the practitioner's position. This case also supports that point made earlier about the different levels of risk associated with the different ways in which medicine is administered for example, orally as opposed to intravenously. The more poisonous the medicine the more care one must exercise since the degree of risk to the patient is increased. In this case the young doctor, no doubt stressed by his new environment and the lack of supervision to which he had become accustomed as part of his training simply failed to think. The information he needed to avoid the risk was apparently on the labelling of the containers of the medicine. All he had to do was read. The difference between being a qualified and registered medical practitioner and a student doctor is that there is no longer anyone else to take responsibility for what goes wrong. This case also demonstrates that if one chooses to engage in an occupation that represents a greater risk to peoples' life and health than many others, the minimum degree of care and skill that is required is concomitantly higher. The lack of adequate instructions from the more experienced doctor in this case could not save the defendant. Although a failure to give adequate instructions to employees dealing with a dangerous substance has been held to amount to negligence on the part of the employer[2], the court held in this case

---

2 See *Oosthuizen v Homegas (Pty) Ltd* 1992 (3) SA 463 (O). The plaintiff had instituted action in a Provincial Division for damages arising out of injuries which he had sustained in an explosion on the defendant's premises in Bloemfontein. It was alleged that the explosion had been caused by the defendant's negligence. The plaintiff had, at the relevant time, been the manager of the defendant' Bloemfontein branch. The defendant's business had been the selling of liquid petroleum gas in cylinders which it had purchased from a supplier and resold to the public. Members of the public also brought smaller gas cylinders to defendant's premises for filling with gas and defendant would decant gas into their cylinders. It appeared that, in so doing, the defendant acted illegally as it was in conflict with the licence granted to the defendant by the Bloemfontein Municipality. The plaintiff continued to decant gas illegally on the premises in order to meet his sales targets set by the defendant. It has been made clear to the plaintiff and others by the defendant that it would become necessary to close the Bloemfontein branch should the turnover required by the defendant's head office not be achieved. At the time of the explosion, the process of decanting gas into small cylinders was carried out in a strong-room on the defendant's premises by means of a machine which had been sent to the defendant's Bloemfontein branch by its head office. There were no windows or other means of proper ventilation in the strong-room, such proper ventilation being necessary to enable free-flowing air to clear the strong-room of gas and thus prevent the accumulation of gas therein. The evidence revealed that the persons whose responsibility it was to decant the gas had a very rudimentary knowledge of the dangers involved in their work and that none of them, including the plaintiff, had received any training in working with gas. On the day of the explosion, the plaintiff had gone

that the defendant had failed to exercise the minimum level of care and skill that was expected of him.

8.2.2 R v van der Merwe[3]

Facts

The accused was a medical practitioner charged with culpable homicide arising from his treatment of the deceased with dicumarol. Evidence showed that the deceased had died of dicumarol poisoning as the result of an overdose.

Judgment

Roper J after defining negligence told the jury that this is a definition which applies to all forms of negligence and that the definition has a special application in the case of a member of a skilled profession such as a doctor because such a person holds himself out as possessing the necessary skill and he undertakes to perform the services required of him with reasonable skill and ability. He is thus expected to possess a degree of skill which corresponds to the ordinary level of skill in the profession to which he belongs. In deciding whether such a person is negligent or not the question is whether, applying the definition of negligence, he has exercised the degree of care and skill which a reasonable man, who is also skilled in the profession, would employ. He pointed out that although a medical practitioner is not required to bring to bear the highest possible degree of professional skill, he is bound to employ reasonable skill and care – not the highest, not the specialist's skill, but reasonable skill and

---

into the strong-room to ascertain why the decanting of the gas was taking a long time. While he was in the strong-room the explosion occurred. The defendant relied, *inter alia*, on the defence of *volenti non fit injuria*, the defence based on the maxim *nemo ex suo delicto meliorem suam conditionem facere potest* (no one can improve his condition by his own misdeed) and the defence of contributory negligence justifying an apportionment of damages. It was held that it had been proved that the defendant had been negligent in not instructing the plaintiff sufficiently in regard to the danger in doing the work which he either had to do or had to supervise and in not providing reasonably safe premises for the performance of those functions.

3 *Van der Merwe* 1953 (2) PH H 124 (W)

care. He said that in deciding what is reasonable, regard must be had to the general level of skill and diligence possessed and exercised by members of the branch of the profession to which the practitioner belongs. The standard is the reasonable care and skill which is ordinarily exercised in the profession generally. Roper J said that this means that a practitioner cannot hide behind the defence that he did not know enough or was not sufficiently skilled. He said that before a medical practitioner uses a dangerous drug with which he is unfamiliar he must satisfy himself as to the properties of the drug and he cannot defend himself if he is called to account afterwards, by saying that he did not know because it is his duty to know. The court observed that in South African law the test for negligence is exactly the same in civil as in criminal cases and that it makes no difference whether a medical practitioner is sued in the civil courts for damages or is prosecuted in the criminal courts by the state. He also stated that in South African law a man is liable criminally for negligence whether his negligence is gross or slight. The jury returned a verdict of guilty.

Discussion

The point to note about this case is that, as in *van Schoor*[4], the court stated that the test for negligence is exactly the same in civil law as it is in the criminal law – it makes no difference whether a medical practitioner is sued civilly for damages or by a patient who alleges that he has been negligently treated or is prosecuted by the state. The burden of proof in criminal cases though, is heavier than in civil cases since in the latter the plaintiff must only prove his case on a balance of probability, whereas in the latter negligence must be proven beyond reasonable doubt. The other point to note is that the same standard of care is not required of a general practitioner as of a specialist. A specialist is required to employ a higher degree of care and skill concerning matters within the field of his speciality that a general practitioner. In fact one of the current problems within the system of registration of medical practitioners in South Africa is that

4 *Van Schoor* fn 1 *supra*

whilst specialists have defined scopes of practice and may not operate outside of those, a general practitioner's scope of practice is not defined. There is no regulation that prohibits a general practitioner from performing the work of a specialist. In effect this means that a general practitioner can do anything that a specialist may do if he so chooses and not be taken to task for it by the Health Professions Council whilst a specialist may only operate within a relatively narrowly defined scope of practice. Legal principles such as *imperitia culpae adnumeratur* thus come into their own in situations where a general practitioner attempts to do something that should only be undertaken by a medical specialist although for the poor patient this may be cold comfort indeed. Claassen and Verschoor[5] state that if a practitioner presents himself as a specialist in the sense that he handles a case from a specialist's point or view, or he insists on specialist tariffs or he professes to treat a patient with a special degree of knowledge, care, skill and experience, the law will hold him to this pretext. His performance will then have to comply with the standard of conduct of a reasonable specialist belonging to the same speciality the practitioner professes to be a member of. They point out that Potgieter[6] submits that the opposite is also true, namely that when a professional person indicates that he possesses a lower degree of skill than the required minimum standard, and the client knowingly still accepts his services then the professional person need only comply with the expressed lower standard of conduct. The current writer submits that a medical specialist registered as such with the Medical and Dental Board of the Health Professions Council of South Africa will in practice have a very hard time convincing a court or anyone else that the patient accepted a lower degree of skill in treatment falling within the scope of the specialty for which he is registered since a person can only in terms of the Health Professions Act[7] be registered as a specialist once he has satisfied the regulatory body that

---

5 Claassen NJB and Verschoor T *Medical Negligence in South Africa* p15

6 Potgieter JM 1985 *Professionele Aanspreeklikheid* Research Report, Department of Private Law, University of Pretoria

7 Health Professions Act No 56 of 1974. Section 35(3) states that: "No registered person shall take, use or publish in any way whatsoever any name, title, description or symbol indicating or calculated to lead persons to infer that he holds any professional qualification which is not shown in the register in connection with his name,

he has the necessary skill and experience. The Health Professions Act defines a 'speciality', in relation to a medical practitioner, dentist or psychologist, as including any particular subdivision of a speciality in which such medical practitioner, dentist or psychologist specializes or intends to specialize. Section 18 of the Act requires the registrar to keep registers in respect of medical practitioners, dentists, interns, student interns, medical students, dental students, psychologists, intern-psychologists and psychology students or any other health professionals as determined by the council and persons doing community service in terms of section 24A and, on the instructions of the professional board, to enter in the appropriate register the name, physical address, qualifications, date of initial registration and such other particulars (including, in the case of medical practitioners, dentists and psychologists, *the name of their speciality or category*, if any) as the professional board may determine, of every person whose application for registration in terms of section 17 (2) has been granted. In June 2001 the Minister of Health made regulations[8] in terms of section 35 of the Health Professions Act read together with section 61(1) (f) of that Act concerning specialities and subspecialities in Medicine and Dentistry. In those regulations a general practitioner is defined as "a medical practitioner or a dentist not registered as a specialist", a "medical specialist" is defined as a "medical practitioner who has been registered as a specialist in a speciality or related specialties and a subspeciality (if any) in medicine in terms of these regulations and a "specialist" is defined as a "medical practitioner or a dentist who has been registered as a specialist in a speciality or relation specialities and subspeciality (if any) recognised in terms of these regulations *and who confines his or her practice to such speciality or related specialities and subspeciality* (if any)" (writer's italics). In these regulations the requirements for registration of a

---

nor shall any registered person practise as a specialist or hold himself out to be a specialist unless his speciality has been registered as prescribed." Section 35 1A states that:" (1A) Where a person fails in respect of any provision of a regulation made under section 61 (1) (f) and applies to have a speciality registered in terms of this section, the council may require him or her to pass to the satisfaction of the council, on a date and at a place determined by the council, an examination prescribed under subsection (1B) before examiners appointed by the council, for the purpose of determining whether his or her professional knowledge and skill in the professional field of his or her speciality is sufficiently adequate to enable him or her to practise as a specialist."

8 Regulations Relating to the Specialities and Subspecialities in Medicine and Dentistry Gazette No 22420 Notice No 590 Regulation Gazette No 7098 of 29 June 2001

medical practitioner in the category independent practice (specialist) are set out and include *inter alia* proof of specialist qualifications, the prescribed period of internship training, and further 12 months experience in any one of more of the disciplines of medicine, including research. In terms of section 14 of the regulations, a medical practitioner or a dentist who holds a registration as a specialist in terms of the Act is required in the case of a speciality to confine his or her practice to the speciality or related subspecialities in which he or she is registered and in the case of a subspeciality confine his or her practice mainly to the subspeciality in which he or she is registered and the retention of his or her registration as a specialist in the relevant speciality, related subspecialities or subspeciality is contingent on whether he or she so confines his or her practice.

These regulations further provide that a specialist may charge fees for examinations or procedures which usually pertain to some other speciality only if such examination or procedures are also recognised in his or her speciality, related subspecialities or subspeciality as generally accepted practice and provided that such fees are not higher than those charged by general practitioners for the same examinations or procedures and that such examinations or procedures are carried out only for his or her *bona fide* patients.

In terms of regulation 16(2) a specialist may treat any person who comes to him or her direct for consultation but may not in terms of regulation 15 take over a patient from any other practitioner, whether he or she is a specialist or a general practitioner, except with the consent of the practitioner concerned, which consent may not be unreasonably withheld.

Regulation 18 requires a specialist who is consulted by a patient or who treats a patient to take all reasonable steps to ensure collaboration with the patient's general practitioner.

From the foregoing the differences between general practitioners and specialists are very clear. This said, in South Africa it is not unusual to find a doctor retaining his registration as a general practitioner whilst practising some speciality which interests her and in which she has received further academic and practical training largely because of the requirement that to be registered as a specialist, one must confine one's practice to the speciality. This is because general practice is just that – general. One can do anything as a general practitioner – even specialised work.

There may well be those who feel that this situation is far from ideal, while others may argue that there is sufficient control in not allowing such a general practitioner to charge the fees that a specialist would in respect of his specialist work. In response to the latter it is noted that there is no legal restriction[9] on what a practitioner can charge in terms of fees provided that he is reasonable[10], that many patients do not belong to medical schemes and would not necessarily know whether the rate was that of a specialist or a general practitioner and that where a patient's medical scheme refuses to pay the doctor the higher, specialist, rate, he or she is legally entitled to claim the balance from the patient or to require the patient to pay cash up front and then submit the claim to the medical scheme. It certainly seems that in a legal environment in which a general practitioner may do pretty much as he pleases in terms of work requiring specialised skill and experience, there is much to be said for a more rigorous system of ongoing monitoring and evaluation of general practitioners than presently exists in South Africa. Alternately, there should be attempts to define the scope of practice of a general practitioner to areas and levels within those areas with reference to the scopes of practice of specialists. The problem with this latter solution is that it will not necessarily promote quality of health

---

9 In fact the Competition Commissioner recently ruled that the practice of publishing tariffs by both the South African Medical Association and the Board of Healthcare Funders which related *inter alia* to fees that general practitioners and specialists may charge amounts to restrictive horizontal practices in terms of the Competition Act are therefore illegal.

10 The charging of fees that are excessive or unreasonable could constitute unprofessional conduct which is subject to disciplinary action by the relevant Board.

care services amongst general practitioners as would the first suggestion and also, from the point of view of the currently significantly under serviced need of the South African population to be able to access health care services and the severe shortage of medical specialists in the country, it is likely to reduce rather than promote general access to health care services, particularly specialised ones.

It is to be noted that in addition to the legal penalties and sanction that may be imposed upon a health professional for acting negligently, it is also likely that the professional body that has registered him or her will be able to take disciplinary measures in respect of unprofessional conduct. In terms of the Health Professions Act "unprofessional conduct" means improper or disgraceful or dishonourable or unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy. There is a similar definition in the Pharmacy Act[11] and the Allied Health Professions Act[12](AHPA). Although the term is not defined in the Nursing Act[13], section 28(1) states that the South African Nursing Council may institute an inquiry into any complaint, charge or allegation of improper or disgraceful conduct against any person registered or enrolled under the Act and, on finding such person guilty of such conduct, may impose any of the penalties referred to in section 29 (1): Provided that in the case of a complaint, charge or allegation which forms or is likely to form the subject of a criminal case in a court of law, the council may postpone the holding of an inquiry until such case has been disposed of. The question as to the level of care required to be exercised by a general practitioner who practices a certain speciality without being registered as a specialist in that field must, it is submitted, logically be that of a reasonable general practitioner who is also

---

11 Pharmacy Act No 53 of 1974. In terms of this Act: 'unprofessional conduct' means improper, disgraceful or dishonourable or unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy;

12 Allied Health Professions Act No 63 of 1982. In terms of the AHPA: 'unprofessional conduct' means improper, disgraceful, dishonourable or unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy;

13 Nursing Act No 50 of 1978

practising that speciality. It cannot be that of the reasonable specialist in that speciality and who is registered as such and who practices exclusively in that field. If, however, the general practitioner holds himself out to be a specialist then he is publicly professing a certain degree of skill and, as Claassen and Verschoor[14] then rightly state, he should be judged by the same standard as a specialist would be judged. In the context of the Cuban doctors that are sent by Cuba to work in South Africa in the public sector in terms of a government-to-government agreement with Cuba, these doctors are registered in a special category by the Health Professions Council of South Africa as general practitioners in the public sector but usually in connection only with a particular field of practice such as obstetrics and gynaecology for example. Such practitioners thus have a special registration as general practitioners which allows them to practice only in the field designated on their registration certificate. This does not mean that they are medical specialists in the sense referred to in the Health Professions Act and regulations. They have not done the extra periods of practical training and engaged in the further studies required of specialists. They are general practitioners confined to a particular practice area and should therefore also be judged by the standard of the reasonable general practitioner rather than that of the reasonable specialist.

Claassen and Verschoor[15] point out that where a practitioner treats a patient without prior consent, and in the absence of a legally recognized ground of justification, he commits assault. However, where the practitioner negligently injures the patient the wrongdoing will not be classified as assault because assault requires fault in the form of intention. They state that even where consent is obtained by a physician, he may still be guilty of contravening a statutory prescription or assault if his conduct is in conflict with the law. It is submitted that informed consent only protects the health professional or health institution where the act or omission complained of falls within the ambit of the

---

14 Claassen and Verschoor fn 5 *supra*

15 See Claassen and Verschoor (fn 5 *supra*) p 127 and the footnotes

consent[16]. Those acts and omissions falling outside of the ambit of the consent are obviously not covered by it and since medical interventions in South Africa are *prima facie* unlawful, the absence of consent or a legally recognised justification will mean that they are unlawful. Thus when a patient submits herself to treatment by a doctor it cannot be said that an implied or tacit term of the contract or an element of the relationship is the understanding that the doctor can act carelessly or negligently in writing out a prescription or administering an overdose of a drug.

Strauss[17] observes that there have been several cases in South Africa in which a doctor was held legally liable for drug damage but these cases invariably involved over-prescribing or over-administration, on account of ignorance or carelessness on the part of the doctor, of drugs that are quite safe when used in accordance with the manufacturer's directions. He states that in a case of a drug which was properly designed, developed, tested, registered and distributed and which was prescribed in conformity with the statutory standards, and which is now alleged to be potentially hazardous to patients, proof of negligence on the part of a doctor may be well-nigh impossible. If there is a strong indication that there was no negligence on the part of the manufacturer, this factor, he submits will weigh even more heavily in the favour of the doctor. Strauss does say that it is not inconceivable that in exceptional circumstances a doctor may be held liable for a defective drug. He notes that there is the possibility that a drug despite all the precautions taken to ensure its safety turns out to be unsafe. The thalidomide disaster immediately springs to mind, he says, but other examples in recent pharmaceutical history may also be cited. Without a doubt there is a duty upon the doctor to keep himself adequately informed on developments in the pharmaceutical field in so far as his profession is affected. Strauss points out that, for example, a doctor were to prescribe or administer a drug despite the

---

16 See Strauss SA and Strydom MJ *Die Suid-Afrikaanse Geneeskundige Reg* p 9 and p 330 who point out that a patient who consents to an operation must also consent to the accompanying procedures, eg the administration of anaesthesia

17 Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues*

fact that its newly discovered risks have been fully described in a medical journal circulating in his area of practice, an inference of negligence can clearly be drawn. This will also be the case when a manufacturer has withdrawn a drug, the safety of which has become suspect and has given wide notice of its decision. Strauss also gives the example in the case of doctors who do their own dispensing or a doctor who gratuitously hands over pharmaceutical samples to a patient, that where the particular medicine has become unsafe or ineffective due to contamination or a chemical reaction, the doctor could be held liable in delict for any harm suffered by the patient as a result[18]. The present writer respectfully concurs with these views.

8.2.3 Esterhuizen v Administrator of Transvaal[19]

Facts

In 1945, when plaintiff, was ten years old, a small nodule showed itself immediately below the ankle of her right leg which she then injured. As a result she experienced some discomfort and her father took her to a medical practitioner. He treated the injury, but also excised the nodule which he submitted for analysis to the South African Institute for Medical Research. It was identified by Dr. Murray, a witness for plaintiff, as a manifestation of a disease known as Kaposi's haemangiosarcoma. This is a malignant tumour occurring mainly on the extremities from there spreading centrally towards the trunk and other parts of the body. It originates in more than one centre at the same time. As the nodules of the disease grow, they eventually coalesce to form larger tumours which are destructive to the neighbouring tissues and lead to ulceration of the skin, destruction of the underlying tissues, infection and ultimately, if not checked in its progress, to death of the patient either by infection, some other incidental disease, haemorrhage or spreading of the disease to vital organs. It is a disease which is very intimately related to the

---

18 Strauss (fn 17 *supra)* at p 294

19 *Esterhuizen* 1957 (3) SA 710 (T)

blood vessels and the cells of which it is composed. It is a slowly but relentlessly progressive disease and the general consensus of opinion at that time was that the average life expectancy of a patient is five to ten years. However cases of death occurring in a shorter period than a year had been recorded and others were on record in which the patient survived for as long as forty years.

The plaintiff's mother was at the time advised that it was necessary for the plaintiff to proceed to the Johannesburg General Hospital for treatment. She was informed that the site where the nodule had been excised would receive X-ray treatment. The plaintiff was taken by her father to the Johannesburg General Hospital and there received superficial X-ray treatment over the site of the excision. She was then sent home. The X-ray machine used for that purpose was referred to as the Chaoul Unit. Plaintiff experienced no pain or discomfort; a week or two later the skin peeled off over the site which had been treated and the wound healed completely. Some three months later, however, further nodules appeared on her right leg, foot and toes, under the left foot, and on the dorsum of the right hand. Once more, accompanied by her father, she was taken to the same institution and there received superficial therapy treatment from the 8th to the 13th October, again by means of the Chaoul Unit, whereafter she was sent home without any ill effects. She was given instructions, however, to report back from time to time, but in any event to do so immediately on new or fresh nodules making their appearance.

During the period 1945 to 1949 she reported back on about ten occasions - but received no treatment. By October 1949, however, fresh nodules once more appeared on all of the plaintiff's extremities. Her father and natural guardian had died previously. Her mother was then living with a second husband in Swaziland, whilst plaintiff resided with her grandfather at Volksrust in order to enable her to attend school there. When the plaintiff's mother was advised of the reappearance of these nodules, she instructed the grandfather to take

plaintiff to the Johannesburg General Hospital for treatment - and in so far as plaintiff's mother was concerned once more to receive such treatment as might be deemed best by the institution's medical authorities. The mother expected that the treatment on this occasion would be the same as on the two previous occasions, and never thought or entertained any idea that it might carry any risk or danger to plaintiff. In October 1949, the plaintiff was admitted as a patient in the Johannesburg General Hospital. Shortly thereafter one of the nodules was surgically excised after an aunt of plaintiff had duly signed and completed a document consenting to operative treatment being carried out on the plaintiff. At the hospital Dr. Cohen took charge of the plaintiff for purposes of administering X-ray treatment to her. At the time he had held a Diploma in Medical Radiotherapy (London University) for some six months, having qualified in April of that year. He had graduated as a doctor at the University of the Witwatersrand in 1942, and after doing further medical and surgical practice in various hospitals in South Africa, proceeded to America in 1946, where he gained some therapy experience - without graduating or obtaining any degree - at the Bellevue Hospital. He then attended the London University, where he studied for the Diploma, which he obtained after some sixteen months.

He stated in evidence that, having examined the plaintiff, he concluded that she required 'radical' treatment. Although aware of the fact that she had received superficial therapy treatment from a certain Dr. Krige on two previous occasions, he decided - as, in his opinion, the disease was rapidly progressing, leaving the plaintiff with an estimated expectation of life of one year - that she required not only deep therapy treatment, but of a dosage measured in 'r' (roentgen) units which, could only be described as 'radical.' Dr Cohen admitted that the dosage and manner of treatment which he worked out and decided to apply to plaintiff was of such a nature or order that he knew beforehand that plaintiff would:

i. Suffer severe irradiation of the tissues in the treated areas and could possibly sustain ulceration of these tissues.

ii. Become disfigured or deformed in the sense that permanent harm would be done to her epiphyses (growing bone ends) in the treated areas, causing a shortening of the limbs and furthermore that cosmetic changes would set in - a feature described by Dr. Cohen as 'permanent visible damage to the skin - a change in pigmentation - causing the skin to become lighter or darker or blotchy with light and dark patches; the skin might become drier and thinner, stopping sweating in the affected area.'

iii. Run a risk and be subjected to a possibility of having to suffer amputation of the treated limbs. These consequences and risks arising from the treatment and dosage worked out by Dr. Cohen were known only to himself and no-one else. The plaintiff's mother had no knowledge of any danger and anticipated none. The plaintiff, who had been admitted to a ward under the charge of a certain Dr. Adno, enquired from him - before treatment was administered - what was going to happen to her, and was told not to worry about it. As a child of fourteen years, she had no reason to anticipate any danger. The danger, if any, accompanying superficial therapy treatment such as the plaintiff received on the two earlier occasions by means of the Chaoul Unit was infinitely less than that attendant on the proposed or contemplated treatment and dosage for which purpose the Maximar Unit was to be used.

There was ample time and opportunity on hand to have procured the consent of plaintiff's guardian to the proposed treatment. Dr. Cohen, the only person with knowledge of the danger and consequences which might or would ensue, was asked in cross-examination whether he did not think that he should have afforded the parents an opportunity to consider the situation and he replied:

'It was my function to cure the disease if it was possible . . . I was fully aware that there would be cosmetic changes... after radiotherapy. I did not consider it necessary to discuss these details with the patient and I had never met the patient's parents . . .. It is not the usual procedure in the radiotherapy department to ask the parents to come.'

During the period of the 1st up to and including the 5th November, 1949, the plaintiff received deep therapy treatment under the Maximar Unit, in accordance

with the technique and the dosage evolved by Dr. Cohen. Her two feet and legs were treated up to approximately the knees whilst both hands were treated up to the wrists. Ten days after the end of the treatment plaintiff noticed blisters forming on the treated areas and experienced a burning sensation. Her condition became worse and according to her mother, who had in the meantime been summoned by plaintiff's aunt, a foul stench hung about the plaintiff's bed. On the 31st December, 1949, the plaintiff, at the request of her mother was transferred to the Volksrust Hospital and later to the Piet Retief Hospital. She was finally readmitted to the Johannesburg General Hospital, where on the 17th May 1950, her right leg was amputated just below the knee. This was followed by a similar amputation of the left leg, necessitated by post-radiation malignant ulcers, and an additional amputation of portion of the stump of the right leg. In 1954 two fingers of her left hand were amputated for the same reason, and the evidence was clear that it would be necessary to amputate the whole of the left hand. In August, 1955, the right hand was amputated at the wrist, resulting in plaintiff now being minus legs, a right hand and faced with the certain prospect of having to lose her left hand - which in any event had been rendered useless by the treatment.

The court observed that even with the treatment the plaintiff was not 'cured' in the ordinary sense of the word. The evidence showed that as the disease was multi-centric in origin and that it could re-occur at any moment in the plaintiff, notwithstanding the fact that she had lost her limbs. A medical expert, Dr. Murray, stated that whilst there was a reasonable prospect that the disease would not re-occur, he could not say, nor was he prepared to say, that the plaintiff has been permanently cured of the disease. The court accepted his opinion. The plaintiff claimed damages against defendant in his capacity as the Administrator of the Transvaal Province, representing the Provincial Administration, under whose jurisdiction public hospitals in the Province were vested by the provisions of Ordinance No 19 of 1946, of which the Johannesburg General Hospital happened to be one.

Judgment

The court, referring to *Stoffberg v Elliot*[20], noted that:

'In the eyes of the law every person has certain absolute rights which the law protects. They are not dependent on statute or upon contract, but they are rights to be respected, and one of the rights is absolute security to the person. . . . Any bodily interference with or restraint of a man's person which is not justified in law, or excused in law or consented to, is a wrong and for that wrong the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to that interference.'

It also observed that in *Ex parte Dixie*[21], Millin J held with reference to a surgical operation, that, as a matter of law,

"such an operation cannot lawfully be performed without the consent of the patient, or, if he is not competent to give it, that of some person in authority over his person. The fact that he is a patient in this hospital does not entitle those in charge of it to perform any surgical operation upon him which they may consider beneficial. They would only be justified in performing a major operation without consent where the operation is urgently necessary and cannot with due regard to the patient's interests be delayed."

The court observed that the sole question to be answered was whether it had been shown that the treatment to which the plaintiff was subjected in November, 1949, took place without lawful consent - a matter which gave rise in itself to yet a further question, viz., what constitutes consent. It was contended for the defendant that Dr Gouws of Volksrust informed the parents that 'X-ray treatment' at the Johannesburg General Hospital was essential. It was proved that the mother at the time thought that unless the plaintiff received such treatment, death would ensue within a short length of time; and it was reasonable to accept that the father of the plaintiff must have shared in that state of mind. The mother, originally and also in 1949 at a time when she was the plaintiff's legal guardian, was content to leave the choice and manner of treatment to the medical authorities at the hospital - and although there was no

---

20 *Stoffberg v Elliot* 1923 CPD 148
21 *Dixie* 1950 (4) SA 748 (W) at p 751

express consent to the treatment, these circumstances coupled with the fact that the father originally, and the grandfather in October, 1949, at the request of the mother, brought the plaintiff to the institution for the very purpose of receiving X-ray treatment, constituted proof of lawful consent to the treatment which the plaintiff in fact received in November, 1949. It was conceded that neither the guardian nor the patient was aware of any possible danger or risk attaching to the treatment - a feature so the argument proceeded, entirely irrelevant and of no consequence to the determination of the defendant's liability. It was contended, that the facts showed that the plaintiff's guardian, if not originally, then certainly in 1949, in effect stated to the defendants servants: 'Do what you think best - preserve life regardless of consequences,' which was consent wide enough to cover the treatment meted out to the plaintiff and which negatived any idea of an unlawful assault on her.

The court was not prepared to uphold this contention. Quoting *Lampert v Hefer, N.O.*,[22] it said that generally speaking, all the numerous authorities without exception, indicate that, to establish the *defence of volenti non fit injuria* the plaintiff must be shown not only to have perceived the danger, for this alone would not be sufficient, but also that he fully appreciated it and consented to incur it. Bekker J referred to *Rompel v Botha*[23] in which Neser J, held:

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

---

22 *Lampert* 1955 (2) SA 507 (AD) at p 508 where Schreiner JA stated: "it is usual to include in the defence *volenti non fit injuria*, or, as I call it for convenience, consent, cases of voluntary acceptance of risk as well as cases of permission to inflict intentional assaults upon oneself, as in the case of surgical operations."

23 *Rompel* T.P.D., 15th April, 1953, unreported. Also referred to in Strauss fn 17 *supra* at p 10

Bekker J held that a therapist, not called upon to act in an emergency involving a matter of life or death, who decides to administer a dosage of such an order and to employ a particular technique for that purpose, which he knows beforehand will cause disfigurement, cosmetic changes and result in severe irradiation of the tissues to an extent that the possibility of necrosis and a risk of amputation of the limbs cannot be excluded, must explain the situation and resultant dangers to the patient - no matter how laudable his motives might be - and should he act without having done so and without having secured the patient's consent, he does so at his own peril. When it was suggested that the plaintiff only had one year to live, according to Dr Cohen and that consequently the treatment was a matter of life and death, the court stated that it was common cause that there was sufficient time to have obtained the consent of plaintiff's guardian if that had been thought desirable or necessary. The court said that the test to be applied in the determination of the question whether a doctor acted negligently or unskilfully in any given case emerged clearly from the decision of Wessels, J.A., in *van Wyk v Lewis* [24] who held that:

"the surgeon (must perform) the operation with such technical skill as the average medical practitioner in South Africa possesses and (must) apply that skill with reasonable care and judgment . . . (he) is not expected to bring to bear on a case entrusted to him the highest possible professional skill but is bound to employ reasonable skill and care and is liable for the consequences if he does not."

Counsel for the defendant referred the court to the remarks of Van Den Heever, J.A., in *Herschel v Mrupe*[25] who stated:

"The concept of the *bonus paterfamilias* is not that of a timorous faintheart always in trepidation lest he or others suffer some injury; on the contrary, he ventures out into the world, engages in affairs and takes reasonable chances."

Counsel contended on behalf of defendant that the facts show, not only that Dr. Cohen was not negligent, but at most, that he took 'a reasonable chance' which

---

24 *Van Wyk v Lewis* 1924 AD 438 at p 456
25 *Herschel* 1954 (3) SA 464 (AD) at p 490

he was obliged to have done in the circumstances of this case, and that if any error was committed, it was an error of judgment is a matter of opinion.

The court nonetheless found as a fact that the dosage and technique employed in the plaintiff's case resulted in the administration to her of X-rays of too high an order, and which exceeded the limits of skin or tissue tolerance, so in the end causing the necrosis and leading to the amputation of these limbs and that he acted without ordinary or reasonable care in a number of respects, which as a matter of probability, either individually or conjunctively, contributed towards the dosage which exceeded the limits of skin or tissue tolerance. It came to the conclusion that the plaintiff's misfortune was not occasioned by chance, or by an error of judgment in a matter of opinion, but by actions on the part of the therapist which fell short of ordinary care and diligence and that the defendant was liable to the plaintiff on both the main and the alternative cause of action. The court awarded damages in respect of artificial limbs, future medical expenses, procuring the services of an assistant and in respect of loss of amenities, disfigurement, pain and suffering.

Discussion

The argument in *Esterhuizen*[26] revolved around whether or not the specific consent of the patient or her guardian was necessary and what constituted such consent. The court emphasised the fact that the consent had to be specific and that it was necessary on the basis of the common law right of absolute security of the person. Blanket consent to the general nature or circumstances of the treatment is not sufficient to save the health care provider from a claim in delict[27]. This is due to the manner in which the courts apply the doctrine of

---

26 *Esterhuizen* fn 18 *supra*

27 See *National Media Ltd And Another v Jooste* 1996 (3) SA 262 (A) in which the court held that: "Consent is only a valid defence for an action for invasion of privacy provided that the invasion takes the form consented to...This principle finds expression in, for example, *O'Keeffe v Argus Printing & Publishing Co Ltd* 1954 (3) SA 244 (C), where the plaintiff had consented to her photograph being used to illustrate a news item, but not as an advertisement. Similarly in *Kidson v SA Associated Newspapers Ltd* 1957 (3) SA 461 (W) the plaintiffs consented to their photographs being used to illustrate a nursing journal, but not in a nationwide appeal for funds in a popular Sunday newspaper. Accordingly, where the consent is based on an express agreement

volenti non fit injuria[28]. The doctrine includes both consent to injury and consent to the risk of injury. Neethling *et al* point out that the expression 'voluntary

---

between the parties, the terms and conditions of such agreement must be strictly observed... In order to rely successfully upon consent as a defence excluding unlawfulness, the appellants must bring themselves within the ambit of such consent."

28 Neethling J, Potgieter JM and Visser PJ, *The Law of Delict* 3rd ed at p 99 –103 (see also the references there cited and discussed) list the requirements for valid consent as follows stating that the law sets specific requirements for valid consent and that this indicates that it applies this particular ground of justification, i.e. consent, with circumspection –

(a) consent must be given freely or voluntarily (*R v McCoy* 1953 (2) SA 4 (SR)) compulsion invalidates the 'consent'. Compulsion does not have to be extreme to invalidate the consent. It can take the form of economic, social or moral coercion.

(b) The person giving the consent must be capable of volition. This does not mean that he must have full legal capacity to act but that he is 'verstandelik ryp genoeg...om die implikasies van sy handelinge to besef en hy nie geesteskrank is of onder die invloed van verdowingsmiddels wat belemmmerend op sy brein inwerk, verkeer nie' [quoting from Van Der Merwe and Olivier p 91 *Die Onregmatige Daad in die Suid-Afrikaanse Reg*]

(c) The consenting person must have full knowledge of the extent to of the (possible) prejudice. It is important that the prerequisite knowledge is present especially where consent to the risk of harm is concerned. In such cases the consenting person must have full knowledge of the nature and extent of the risk in order to consent to such risk.

(d) The consenting party must realise or appreciate fully what the nature and extent of the harm will be. Mere knowledge of the risk or harm concerned is therefore no sufficient; the plaintiff must also comprehend and understand the nature of the harm or risk.

(e) The person consenting must in fact subjectively consent to the prejudicial act. In this regard they refer to the dictum of Innes CJ in *Waring and Gillow Ltd v Sherborne* 1904 TS 340 at p 344: "It must be clearly shown that the risk (of injury) was known, that it was realized, and that it was voluntarily undertaken. Knowledge, appreciation, consent – these are the essential elements; but knowledge does not invariably imply appreciation, and both together are not necessarily equivalent to consent."

(f) The consent must be permitted by the legal order; in other words, the consent must not be *contra bonos mores*. Consent to bodily injury or consent to the risk of such injury is normally *contra bonos mores* unless the contrary is evident. Examples of the latter are cases of participation in lawful sport, medical treatment or cases where the injury is of a very minor nature.

(g) Finally the impairment must fall within the limits of the consent.

See also Burchell J *Principles of Delict* at p68-73; Strauss at p 90 and p 149 and Strauss 'Bodily Injury and the Defence of Consent' 1965 *SALJ* 179; Van der Walt JC and Midgely *Delict Principles and Cases* p112; Boberg PQR *Delict: Principles and Cases vol I: Aquilian Liability* p 724 onwards.

The concept of coercion vitiating consent is cross-cutting in that it applies to consent irrespective of the context in which it is debated. It is submitted that there is little or no difference, in the requirements for consent within the law of delict and other areas of law such as that of contract in which the concept of consent plays a major role. This should be the case for constitutional reasons as much as any other kind because freedom from coercion is implicit in the right to freedom.

The court in *Van Den Berg & Kie Rekenkundige Beamptes v Boomprops* 1028 BK 1999 (1) SA 780 (T) observed that: "Die Engelse reg het egter in die onlangse verlede 'n uitbreiding ondergaan in hierdie verband. Cheshire, Fifoot en Furmston *Law of Contract* (supra) stel dit soos volg op 314: 'It is now clear that in his judgments in *D & C Builders Ltd v Rees and Lloyd's Bank Ltd v Bundy* Lord Denning was suggesting the introduction into English law of not one but two new doctrines, economic duress and inequality of bargaining power. So far the former suggestion has fallen on much more fertile ground than the latter. In delivering the advice of the Privy Council in *Pao On v Lau Yiu Long* Lord Scarman observed that "there is nothing contrary to principle in recognising economic duress as a factor which may render a contract voidable, provided always that the basis of such recognition is that it must always amount to a coercion of will, which vitiates consent".'

In *Atlas Express Ltd v Kafco (Importers and Distributors) Ltd* [1989] 1 All ER 641 (QB) op 645 verwys Tucker R met goedkeuring na die volgende uitlating van Lord Scarman in *Pao On and Others v Lau Yiu and Another* [1979] 3 All ER 65 (PC) op 78–9: 'Duress, whatever form it takes, is a coercion of the will so as to vitiate consent. Their Lordships agree with the observation of Kerr J in *The Siboen and The Sibotre* [1976] 1 Lloyd's Rep 293 at 336 that in a contractual situation commercial pressure is not enough. There must be present some factor "which could in law be regarded as a coercion of his will so as to vitiate his consent". This conception is in line with what was said in this Board's decision in *Barton v Armstrong* [1975] 2 All ER 465 at 476–7, [1976] AC 104 at 121 by Lord Wilberforce and Lord Simon of Glaisdale, observations with which the majority judgment appears to be in agreement. In determining whether there was a coercion of will such that there was no true consent, it is material to enquire whether the person alleged to have been coerced did or did not protest; whether, at the time he was allegedly coerced into making the contract, he did or did not have an alternative course open to him such as an adequate legal remedy; whether he was independently advised; and whether after entering the contract he took steps to avoid it. All these matters are, as was recognised in *Maskell v Horner* [1915] 3 KB 106, [1914–15] All ER Rep 595, relevant in determining whether he acted voluntarily or not. . . .

At common law money paid under economic compulsion could be recovered in an action for money had and received. . . . The compulsion had to be such that the party was deprived of "his freedom of exercising his will". . . . It is doubtful, however, whether at common law any duress other than duress to the person sufficed to render a contract voidable; . . . American law . . . now recognises that a contract may be avoided on the ground of economic duress. The commercial pressure alleged to constitute such duress must, however, be such that the victim must have entered the contract against his will, must have had no alternative course open to him, and must have been confronted with coercive acts by the party exerting the pressure. . . . Recently two English Judges have recognised that commercial pressure may constitute duress the presence of which can render a contract voidable. . . . Both stressed that the pressure must be such that the victim's consent to the contract was not a voluntary act on his part. In their Lordship's view, there is nothing contrary to principle in recognising economic duress as a factor which may render a contract voidable, provided always that the basis of such recognition is that it must amount to a coercion of will, which vitiates consent. It must be shown that the payment made or the contract entered into was not a voluntary act.'

In *Malilang and Others v MV Houda Pearl* 1986 (2) SA 714 (A), Corbett JA commented as follows at p 730: "I turn now to the defence of duress. The form of duress here under consideration is what has been termed 'economic duress'. A number of recent decisions in England appear to have established that in English law commercial pressure exerted on one party to a contract in order to induce him to enter into the contract may amount to economic duress entitling that party to avoid the contract, provided that the pressure amounts to a coercion of the will which vitiates consent. (See *Occidental Worldwide Investment Corporation v Skibs A/S Avanti (The Siboen and the Sibotre)* [1976] 1 Lloyds Rep 293 at 335; *North Ocean Shipping Co Ltd v Hyundai Construction Co Ltd and Another (The Atlantic Baron)* (*supra* at 1182); *Pao On and Others v Lau Yiu Long and Others* (*supra* at 635–6); *Universe Tankships Inc of Monrovia v International Transport Workers' Federation (The Universe Sentinel)* [1980] 2 Lloyds Rep 523 (CA) at 530–1, 541, [1982] 2 All ER 67 (HL) at 75–6, 88–9; *Alec Lobb (Garages) Ltd and Others v Total Oil GB Ltd* [1983] 1 All ER 944 (Ch) at 960.)'" The court in *Malilang* accepted the concept of economic duress as being applicable within the context of the South African law of contract.

The court in *Van den Berg & Kie Rekenkundige Beamptes v Boomprops supra* distinguished Malilang's case, however, on the basis that it was designed in terms of English marine law under the Colonial Courts of Admiralty Act 1890 (32 and 54 Vict Ch 27) and that the Appellate Division had been obliged to apply it in the circumstances. It said that: "Soos reeds gemeld is die uitspraak van Corbett AR in Malilang se saak geen gesag vir die standpunt dat 'economic duress', soos dit in die Engelse reg erken word, deel van ons reg vorm nie."

The court in *Van Den Berg & Kie Rekenkundige Beamptes v Boomprops* went on to hold that the concept of economic duress does not form part of South African law. It observed that "Dat daar interessante ontwikkelinge op hierdie gebied tans in die Engelse reg plaasvind en wel op 'n baie breë front is waar. Sien onder andere Chitty (op cit op 537) oor 'unconscionable bargains and inequality of bargaining power' en die opinie van Denning MR in *Lloyds Bank Ltd v Bundy* [1975] QB 339 (CA) ([1974] 3 All ER 757). Dit is blykbaar dan ook so dat hierdie ontwikkeling in die Engelse reg mag meebring dat die onderskeid tussen 'duress' en 'undue influence' kan vervaag en moontlik mettertyd kan verdwyn. Dit is egter nog nie te sê dat ons eie regsontwikkeling hand aan hand daarmee saamloop nie en dit beteken ook nie omdat ons die Engelsregtelike begrip van 'duress of goods' (in die enger sin) soos hierbo bespreek as in ooreenstemming met ons reg aanvaar het, ons die Engelsregtelike regsbeginsels oor 'duress' oorgeneem het en dat dit sonder meer ook die ontwikkelingsgang in ons eie regswetenskap moet bepaal nie. Sien *Preller and Others v Jordaan* 1956 (1) SA 483 (A) op 493B–C; *Regal v African Superslate (Pty) Ltd* 1963 (1) SA 102 (A) op 106; *Farlam en Hathaway* (op cit op 369 para 4). Daarbenewens moet in gedagte gehou word dat die Engelsregtelike ontwikkeling in hierdie verband grootliks beïnvloed word deur die 'equity' van die Engelse reg en dat ons eie Appèlhof in *Bank of Lisbon and South Africa Ltd v De Ornelas and Another* 1988 (3) SA 580 (A) beslis het dat ons reg nie 'n algemene substantiewe verweer gebaseer op billikheid in die kontraktereg erken nie. Per Joubert AR op 605J–606D. Wat die presiese effek van hierdie saak mag wees op die ontwikkeling van ons reg tot die erkenning van 'n sogenaamde 'economic duress' as grond vir vernietiging van 'n kontrak is nie voor my geargumenteer nie. Ek is nie oortuig dat die beginsels van 'economic duress' in die Engelse reg deel is van ons reg nie. Ek is na geen gesag verwys waarin dit pertinent beslis is nie en ek kon in my eie navorsing ook geen sodanige gesag opspoor nie. Dat ons reg moontlik nog in daardie rigting kan ontwikkel en of in ons gemeenregtelike bronne die nodige aanknopingspunte daarvoor te vind is hoef ek nie oor te besin nie. Ek sien dit nie as my taak waar ek sit as Regter in 'n Hof van eerste instansie nie."

In a different context the court in *Kotze v Kotze* 2003 (3) SA 628 (T) observed that: "Dickson CJ in the Supreme Court of Canada (*R v Big M Drug Mart Ltd* (1985) 13 CRR 64 (SCC) ((1985) 18 DLR (4th) 32; [1985] 1 SCR 295; 18 CCC (3d) 385; [1986] LRC (Const) 322)): 'A truly free society is one which can accommodate a wide variety of beliefs, diversity of tastes and pursuits, customs and codes of conducts. A free society is one which aims at equality with respect to the enjoyment of fundamental freedoms and I say this without any reliance upon s 15 of the Charter. Freedom must surely be founded in respect of the inherent dignity and the inviolable rights of the human person. The essence of the concept of freedom of religion is a right to entertain such religious beliefs as a person chooses, the right to declare religious beliefs openly and without fear and hindrance or reprisal, and the right to manifest religious belief by worship and practice or by teaching and assimilation. But the concept means more than that. Freedom can primarily be exercised by the absence of coercion or constraint. If a person is compelled by the state or the will of another to a cause of action or inaction which he would not otherwise have chosen, he is not acting of his own volition and he cannot be said to be truly free. One of the major purposes of the Charter is to protect, within reason, from compulsion or restraint. Coercion includes not only such blatant forms of compulsion as direct commands to act or refrain from acting on pain of sanction,

assumption of risk' by contrast, is sometimes used to imply *consent to the risk of injury*, a ground of justification, and sometimes to refer to *contributory intent* (a ground for excluding fault or culpability). The recommend that one should ascertain precisely what happened in a particular situation – whether the wrongfulness was excluded because of the consent of the injured, or whether the negligence of a defendant was cancelled by the plaintiff's intention (contributory intent) or whether, although the plaintiff neither consented not had contributory intent, he was in fact contributorily negligent in respect of his damage because he acted in a manner different from that of the reasonable man[29].

It is submitted that from a certain perspective the application of the principle of *volenti non fit injuria* in the law of delict may be seen as the recognition of a contract between the relevant parties to the effect that the one agrees to the contemplated harm and will not 'hold it against' the other who is inflicting the harm. However, it is not necessarily the case that the maxim represents a contract in every instance. It can be applied in circumstances where no contract exists. A contract only arises where there is an intention between the parties to

---

coercion includes indirect forms of control which determine or limit alternative courses of conduct available to others. Freedom in a broad sense embraces both the absence of coercion and constraint, and the right to manifest beliefs and practices. What may appear good and true to a majoritarian religious group, or to the state acting at their behest, may not, for religious reasons, be imposed upon citizens who take a contrary view.'"
In *Ex Parte Coetzee et Uxor* 1984 (2) SA 363 (W) the applicants had married out of community of property on 5 March 1982. An antenuptial contract was executed on the same day and registered on 17 March 1982. In an application for cancellation of the contract, the applicants contended that they had concluded the contract reluctantly and purely as a consequence of the pressure exerted by a parent, who had threatened to exclude them from access to his home should they marry in community of property. The parties were young and inexperienced, and the parental pressure, coupled with the advice of a minister to preserve the family peace, had led to a decision which subsequently, because of dissatisfaction and self-reproach, threatened the happiness of their marriage. It was held that, while the pressure exerted by the father did not constitute undue influence, coercion or *metus*, the parties had, on the facts, shown good cause for cancellation. The contract accordingly cancelled as from the date of the order to that effect. See also *BOE Bank Bpk v Van Zyl* 1999 (3) SA 813 (C). In *BOE Bank Bpk v Van Zyl* 2002 (5) SA 165 (C) it was held that an overarching ground of avoidance based on the absence of *bona fides* or the improper procurement of consensus was not recognised in South African law. The court said that was no authority for it in the decisions of the Supreme Court of Appeal, and it was not for the Court to depart from settled rules without proper direction from that source. There was also no authority for the statement that the distinctions between duress, misrepresentation and undue influence as well as the recognised requirements for these concepts had to be dispensed with. The court emphasised that for avoidance of a contract on the ground of duress, the threat must be one of imminent or inevitable harm. It said that the threat that a family member would be prosecuted if the suretyship agreement was not signed did not satisfy this requirement and that the feared harm, viz incarceration of family member, had to be considered in the light of the relevant facts and legalities. The decision *in BOE Bank Bpk v Van Zyl* 1999 (3) SA 813 (C) to the effect that a suretyship agreement had been entered into under duress was consequently reversed.

29 See Neethling *et al* fn 28 *supra* p 97 and footnote 346

create one. Consent in the sense of the maxim[30] can be a precursor to a contract but it is not proof in itself that a contract came into existence between the parties[31]. Contracts can be verbal or written, tacit, implied or express. The law of delict may be seen as saying in the context of health service delivery that bodily injury is harmful but if a patient consents (or agrees) to such injury and its consequences then this justifies the harm in that it does away with the element of wrongfulness required for a successful delictual claim. In the context of private health services delivery at least, consent is likely to be as much a contractual concept as it is delictual due to the fact that the patient is usually in terms of the same transaction contracting for health services and undertaking to pay therefor. However, the consent could also be precontractual and may be one of the conditions that induced the contract rather than a term of the contract itself.

In light of the foregoing discussion, an interesting question arises in the context of the contractual or non-statutory limitation of constitutional rights as to whether the application of the principle in delict of *volenti non fit injuria* in the

---

30 The maxim requires more than just 'mere' consent. It was stated by the court in *Van Wyk v Thrills Incorporated (Pty) Ltd* 1978 (2) SA 614 (A) that: "To sustain this defence [of volenti non fit injuria] respondent must show not merely that the deceased had knowledge of the danger, but also that *with the full appreciation of its nature and extent he voluntarily elected to encounter it*, or, as it is usually put, consented to take the risk upon himself. See *Waring & Gillow Ltd v Sherborne* 1904 TS 340. Although *Santam Insurance Co Ltd v Vorster* 1973 (4) SA 764 may be distinguished from the instant case on the basis that the latter deals with the assumption of a known risk, the following dictum at 777B is highly relevant: "... it is I think fair to say that the general tenor of the judgments is to decide against the applicant on the volenti ground." Again in *Waring & Gillow v Sherborne* (*supra* at 344) Innes CJ said that this type of defence must be applied 'cautiously and with circumspection'. No warning specifically referred to the date or dealt in any way with the additional danger to be encountered there. The warnings themselves were silent as regards possible acts of negligence on the part of the respondent."[writer's italics]
With regard specifically to warnings that would obviate liability and effectively activate the acceptance of the risk by the customer, the court stated that: "An exemption of liability as set out in the above mentioned warnings must be held to exclude liability for negligence. *South African Railways & Harbours v Lyle Shipping Co* 1958 (3) SA 416; *Essa v Divaris* 1947 (1) SA at 767. As respondent did not endeavour to exclude negligence in its warnings or exemption clauses on its tickets, the warnings themselves were insufficient to exempt respondent from liability."

31 *Volenti non fit injuria* is usually raised in the form of a defence rather than the term of an agreement. Thus Harms JA observed in *National Media Ltd And Another v Jooste* fn 27 *supra* that: "This does not mean that the delictual nature of the claim is thereby compromised. The breach of the agreement is relevant to the claim in the sense that it may be a determinant of the scope of the complainant's 'privaathoudingswil'. Also, the general sense of justice of the community requires, in my judgment, due compliance with the terms of such an agreement. If, as here, it is breached intentionally, the breach may be a relevant fact to consider in assessing the wrongfulness (in a delictual context) of the publisher's action. On the other hand, had publication taken place according to the terms of the agreement, the publication of the erstwhile private facts could not have been wrongful for several reasons, such as lack of 'privaathoudingswil', consent and *volenti non fit iniuria*. (Where the one defence begins or the other ends is, from a practical point of view, difficult to discern and probably often of no consequence.)"

context of health services delivery constitutes a waiver of the patient's constitutional rights to bodily and psychological integrity especially in the context of an indemnity clause in hospital admission form. Is consent to medical treatment a form of waiver, i.e. contract, or is it something else? If constitutional rights cannot be limited except in terms of the provisions of section 36 of the Constitution and the consent or *volenti non fit injuria* principle constitutes waiver then this puts providers of health care services in a legally untenable position. It has been observed previously that there is a considerable weight of authority to the effect that constitutional rights cannot be contractually waived[32]. Christie[33] makes the point that when the parties to an existing contract come together in an agreeing frame of mind and formally or informally agree to vary or discharge their contract, there is no difficulty about describing what has happened as a variation or discharge by agreement, or a cancellation by agreement. But when one of the parties by his words or actions or inaction has evinced an intention not to enforce one or more or all of his rights conferred by the contract, whichever word seems most appropriate is selected from a list which includes abandonment, acquiescence, release, renunciation, surrender, election, relinquishing of a right and waiver. Christie observes that of these words by far the most commonly used is 'waiver' which is regarded in many of the cases as interchangeable with any of the other words. He notes that waiver of a right conferred by the terms of a contract being itself a contract, it can be established without the necessity to establish the requirements of estoppel. A party relying on waiver need only show that he has accepted, usually tacitly, the other party's express or tacit offer to release him from his obligations, but a party relying on estoppel must go further and show that he has acted to his detriment in reliance on the other party's words or conduct. Christie notes that it follows from the contractual nature of waiver of a right conferred by the terms

---

32 *ABBM Printing & Publishing (Pty) Ltd v Transnet Ltd* 1998 (2) SA 109 (W); *Community Development Board v Revision Court, Durban Central, and Another* 1971 (1) SA 557 (N) at 565B; *Tellis and Others v Bombay Municipal Corporation and Others; Kuppusami and Others v State of Maharashtra and Others* 1987 LRC (Const) 351 (SC), a decision of the Supreme Court of India at 366E–I; *S v Frames (Cape Town) (Pty) Ltd* 1995 (8) BCLR 981 (C) at 989E–J; *Maharaj v Chairman, Liquor Board* 1997 (1) SA 273 (N) at 276J–277B; Hogg *Constitutional Law of Canada* (Carswell, 1991) at 34–1

33 Christie RH*The Law of Contract* p 507

of a contract that the intention to waive must be communicated to the other party. Until then the party who has decided to waive may change his mind as pointed out by Innes CJ in *Mutual Life Insurance Company of New York v Ingle*[34]. Christie observes further that a further result of the contractual nature of a waiver is that as soon as the contract to waive a right conferred by the terms of a contract is concluded, that right is irrevocably destroyed. It may be replaced by a new right by agreement between the parties but a waived right cannot be resuscitated by a purported withdrawal of the waiver. Christie points out that *dicta* in the Appellate Division have equated waiver with election and says that the equation may be accepted up to a point but it must not be allowed to blur the distinction between waiver of a right conferred by the terms of a contract and waiver of a right conferred by law. He notes that waiver of a right conferred by the terms of a contract is itself a contract but waiver of a right conferred by law, even in a contractual context, is not[35].

Despite this observation on the part of Christie, for which he cites no authority, the requirements of proof of waiver are remarkably similar to the requirements

---

34 *Ingle* 1910 TPD 540 at p550

35 In *Girdwood v Girdwood* 1995 (4) SA 698 (C) the respondent, relying on *Schutte v Schutte* 1986 (1) SA 872 (A), argued that it was not incompetent, unlawful *or contra bonos mores* for parties to contract out of the statutory right to apply for the variation of a maintenance order in terms of s 8(1) of the Divorce Act 70 of 1979, and that clause 10 of the agreement constituted an unequivocal waiver by the parties of their right to claim further relief pertaining to matters such as maintenance payable by the one to the other. It was held although it had to be accepted that a waiver by a spouse of his or her statutory right to apply for a variation of a maintenance provision was not in conflict with public policy, there had to be a clear and unequivocal indication in the agreement that such statutory right had been waived. It was further held that the Court, as upper guardian of all dependent and minor children, had an inalienable right and authority to establish what was in the best interests of the children, and to make corresponding orders to ensure that such interests were effectively served and safeguarded, and that no agreement between the parties could encroach on this authority. The court said that clause 10, the umbrella clause excluding further claims between the parties, could not be regarded as a waiver of rights relating to aspects such as custody of, access to, and maintenance for minor children, which matters had been provided for in the agreement in the present case because such waiver would inevitably be contra bonos mores. It held that before the appellant could be deprived of her statutory right to apply for variation of the maintenance provision, there would have had to be some clear indication in the agreement that she had been fully aware of such statutory right at the relevant time and had expressly, or by conduct, waived or abandoned it, and that no such indication appeared from the cited clauses or from any other part of the agreement.
In *Claassens v Claassens* 1981 (1) SA 360 (N), Didcott J held (at 373B) that the waiver of a right to claim an increase in maintenance does not infringe public policy. In *Schutte v Schutte supra* van Heerden JA took cognisance of English law, which does regard a waiver of this nature as contra bonos mores. The court held, however, (at 884A), that other considerations apply in England from those applicable in South Africa, including the fact that, in England, a divorcee has a statutory right to claim maintenance even if she was not granted maintenance at the time of dissolution of the marriage.

for proof of an implied term of a contract[36]. It is submitted that in the context of health care services the situation is complicated by the fact that there is often a contractual overlay in the situation that gave rise to the delict. Christie observes that a waiver of a right derived from a contract is itself contractual in nature but this is not necessarily true of the waiver of a statutory right. In the context of health care services, however, the patient usually agrees to 'waive' his or her constitutional rights on the basis of a contract which he enters into with the health care provider. In the private sector in particular, the patient's consent to the contemplated treatment is obtained on a hospital admission form in the case of inpatient treatment. In the case of non-institutional providers such as general practitioners and dentists, written consent is often not obtained at all or only at the beginning of the relationship when the patient fills in a patient registration form in which case, as a 'blanket' consent', it is not worth the paper it is written on most of the time[37]. In the case of the public sector, the argument for the existence of a contractual relationship between patient and provider is possibly a

---

36 In *Road Accident Fund v Mothupi* 2000 (4) SA 38 (SCA) the Supreme Court held that: Waiver is first and foremost a matter of intention. Whether it was the waiver of a right or a remedy, a privilege or power, an interest or benefit, and whether in unilateral or bilateral form, the starting point invariably was the will of the party said to have waived it. The test to determine intention to waive has been said to be objective. *Palmer v Poulter* 1983 (4) SA 11 (T) at 20C - 21A; *Multilateral Motor Vehicle Accidents Fund v Meyerowitz* 1995 (1) SA 23 (C) at 26H - 27G; *Bekazaku Properties (Pty) Ltd v Pam Golding Properties (Pty) Ltd* 1996 (2) SA 537 (C) at 543A - 544D). That said the court, meant, firstly, that the intention to waive, like intention generally, was adjudged by its outward manifestations (*Traub v Barclays National Bank Ltd*; *Kalk v Barclays National Bank Ltd* 1983 (3) SA 619 (A) at 634H - 635D; *Botha (now Griessel) and Another v Finanscredit (Pty) Ltd* 1989 (3) SA 773 (A) at 792B - E); secondly, that mental reservations, not communicated, were of no legal consequence (*Mutual Life Insurance Co of New York v Ingle* fn 30 *supra* at 550); and, thirdly, that the outward manifestations of intention were adjudged from the perspective of the other party concerned, i.e. from the perspective of the latter's notional alter ego, the reasonable person standing in his shoes. The outward manifestations of intention could consist of words (i.e. express waiver) or of some other form of conduct from which the intention to waive was inferred, or even of inaction or silence where a duty to act or speak existed (i.e. tacit or inferred waiver). Because no one was presumed to waive his rights, the onus was on the party alleging it and clear proof was required of an intention to do so. The conduct from which waiver was inferred had to be unequivocal, that is to say, consistent with no other hypothesis. (*Ellis and Others v Laubscher* 1956 (4) SA 692 (A) at 702E - F), (*Hepner v Roodepoort-Maraisburg Town Council* 1962 (4) SA 772 (A) at 778D - 779A; *Borstlap v Spangenberg en Andere* 1974 (3) SA 695 (A) at 704F - H). The conduct from which waiver is inferred, so it has frequently been stated, must be unequivocal, that is to say, consistent with no other hypothesis. The court observed that 'It is a well-established principle of our law that a statutory provision enacted for the special benefit of any individual or body may be waived by that individual or body, provided that no public interests are involved. It makes no difference that the provision is couched in peremptory terms.'(*SA Eagle Insurance Co Ltd v Bavuma* 1985 (3) SA 42 (A) at 49G - H.) In *Transnet Ltd v Goodman Brothers (Pty) Ltd* 2001 (1) SA 853 (SCA) the court held that: "A waiver of a right is a limitation thereof. One must be careful not to allow all forms of waiver, estoppel, acquiescence, etc to undermine the fundamental rights guaranteed in the Bill of Rights. In my view, a strict interpretation of s 36(1) is indicated." The dictum in *SA Eagle* is clearly not consistent with the view that constitutional rights cannot be waived if one regards the Constitution as a simply another statute. Obviously this case was decided before the Constitution and so the court was not obliged to consider the matter in this context.

37 Consent to treatment, and a waiver of a right must be specific and in the full knowledge of the particular risks and potential consequences involved. 'Blanket consents' such as those under discussion cannot possibly be argued as sufficient to address these requirements.

bit weaker than in the case of the private sector but there are certain instances in which one could definitely show contractual relationship between public sector providers and their patients. One could argue that waiver or consent to medical treatment can be by conduct as well as expressly and in writing. However there are fairly strict requirements for tacit or implied waiver of a right[38]. It is submitted that even if the possibility of waiver of a constitutional right is recognised, the courts should be extremely reluctant to recognise an implied or tacit waiver of such a right because of the dangers of undermining these rights that were so hard won in the process of drafting the Bill of Rights in the Constitution and because of the very real imbalances of power that still exist between consumers and suppliers of goods and services in many contexts in South Africa, not least of which is health care context. In comparison with the

---

38 In *Modise and Others v Steve's Spar, Blackheath* 2001 (2) SA 406 (LAC) the court observed that: "In *Laws v Rutherfurd* 1924 AD 261 at 263 Innes CJ said in effect that, where conduct is relied upon to found a waiver of a right, such conduct must be 'plainly inconsistent with an intention to enforce such right'. (See also *Hepner v Roodepoort-Maraisburg Town Council* 1962 (4) SA 772 (A) at 778F - G.)" In *Xenopoulos And Another v Standard Bank Of SA Ltd And Another* 2001 (3) SA 498 (W) at 511D – F, the court held that what has to be established is an unequivocal act indicating a waiver of a right or remedy. In this regard the onus lies on the party alleging that a decision or act of the other party precludes the latter from exercising the remedy which the latter party seeks to enforce. (At 511D - F.) In *Bikitsha v Eastern Cape Development Board And Another* 1988 (3) SA 522 (E) the court stated: "There can be no waiver of a right without an intention to do so. As stated in *Pretorius v Greyling* 1947 (1) SA 171 (W) at 177: 'Waiver is not to be presumed, it must be proved; and not only must the acts which constitute waiver be shown to have occurred, but it must appear from these acts or otherwise that there was an intention to waive.'" In *Harksen v Attorney-General, Cape, And Others* 1999 (1) SA 718 (C) Friedman JP and Brandt J noted that: "The requirements for an implied waiver of legal professional privilege are, firstly, that the privilege holder must have full knowledge of his rights and, secondly, that he must have so conducted himself that, objectively speaking, it can be inferred that he intended to abandon those rights. (See, for example, *Laws v Rutherfurd* 1924 AD 261 at 263; *Borstlap v Spangenberg en Andere* 1974 (3) SA 695 (A) at 704F–H.) There is also authority to the effect that legal professional privilege may be imputedly waived where the privilege-holder so conducts himself that, whatever his subjective intention might be, the inference must in fairness be drawn that he no longer relies on his privilege. (See, for example, *Attorney General, Northern Territory v Maurice and Others* (1986) 161 CLR 475 (HCA) at 481 ((1987) 61 ALJR 92); *Goldberg and Another v Ng* [1996] 185 CLR 83 (HCA); *Peacock v SA Eagle Insurance Co Ltd* 1991 (1) SA 589 (C) 591–2.) *Wigmore On Evidence* 3rd ed vol 8 in the oft-quoted passage in para 2327 does not appear to draw a distinction between an implied waiver and an imputed waiver. Having posed the question: 'What constitutes a waiver by implication?', the author supplies the following answer: 'Judicial decision gives no clear answer to this question. In deciding it, regard must be had to the double elements that are predicated in every waiver, i.e. not only the element of implied intention, but also the element of fairness and consistency. A privileged person would seldom be found to waive, if his intention not to abandon could alone control the situation. There is always also the objective consideration that when his conduct touches a certain point of disclosure, fairness requires that his immunity shall cease, whether he intended that result or not. He cannot be allowed, after disclosing as much as he pleases, to withhold the remainder. He may elect to withhold or to disclose, but after a certain point his election must remain final.' " The court in *Peacock v SA Eagle Insurance Co Ltd* 1991 (1) SA 589 (C) refused to recognise an argument of implied waiver whether there was no clear intention to waive the right or privilege, stating that: "It would seem preferable, therefore, to speak rather of imputed waiver, where, as here, an actual intention to waive cannot be inferred on the facts." It went on to state that it is necessary to consider whether in the circumstances of the present case it is fair that the privilege in respect of the statement be lost.

rest of the world South Africa is still fairly backward in terms of laws for the protection of consumers against unreasonable or unfair contractual terms[39].

This issue of waiver of constitutional rights has been discussed in more detail previously and will not be further considered here. The question is whether this purported waiver of the constitutional right to bodily and psychological integrity is valid, whether it is valid in terms of the law of contract or upon some other legal basis and whether it is in fact a waiver at all.

As stated previously, waiver does not necessarily equate with the exercise of a choice not to exercise a right[40]. A person's decision not to vote does not mean

---

39 The South African Law Commission noted in its Report in 1998 on Project 47: *Unreasonable Stipulations In Contracts And The Rectification Of Contracts* that: "It happens daily that individuals voluntarily enter into contracts with one another, or with banks, building societies, financial institutions, wholesalers or retailers, in the expectation that the contracts will satisfy their needs and aspirations, only to find subsequently that, in practical application, the contracts as a whole or some of their terms are unjust or unconscionable." It noted with regard to the judgment in *Bank of Lisbon and South Africa (Ltd) v De Ornelas and Another* that: "For those hoping that our courts would develop a doctrine of relief in cases of unconscionability, the judgment was a great disappointment. Only legislative intervention can now correct its implications. The research team that worked on the project found that: Courts in Germany, England, the USA, Sweden, Israel, the Netherlands and Denmark may take judicial action against unfair terms, in addition to which preventative control may also be used against unfair terms.

40 De Waal J, Currie I, and Erasmus G, *The Bill of Rights Handbook* (Fourth edition) state at p 42 that "Although the distinction may be difficult to make in some cases, the waiver of fundamental rights should be distinguished from a decision to exercise a fundamental right. Where a person chooses not to take part in an assembly or not to join an association they cannot later complain about a violation of their freedoms of assembly or association. The same applies when an arrested person makes an informed choice to co-operate with the police by making a statement or a confession, or when a person allows the police to search their home. Such a person may not object at their trial that the introduction of the evidence violates their right to remain silent or their right to privacy of their home. In principle, the accused may nevertheless object to the use of the evidence if it would render the trial unfair. But in the absence of other circumstances (such as that the accused was improperly persuaded to co-operate) it is difficult to see why the use of the evidence would result in an unfair trial. Waiver is quite different. One is dealing with waiver when someone undertakes not to exercise a fundamental right in future. For example, a contractual restraint of trade is an undertaking to waive the s22 right to occupational freedom for a certain period of time. Or a person may undertake not to disclosure sensitive information, or to vote for a certain political party on election day, or to perform nude on stage or to attend religious instruction in a private school. These are, respectively, attempts to waive the rights to freedom of expression, to vote, to privacy and to freedom of religion. The question is then whether someone may be obliged to honour such an undertaking even if they subsequently change their minds. A few general observations must be made at the outset. A waiver cannot make otherwise unconstitutional laws or conduct constitutional and valid. Section 2 of the Constitution provides that laws or conduct inconsistent with the Constitution is invalid."
It is submitted that this statement has to be qualified to allow for situations in which the Constitution itself envisages that consent can render an otherwise unconstitutional action constitutional. An example is to be found in section 12(2) in which a person may not be subjected to medical or scientific experiments without their informed consent. It is also submitted that consent as a legitimating factor is implicit in the section 12(2) right to make decisions concerning reproduction so that a person can decide to be sterilised and that with the informed consent of the patient such sterilisation will be constitutional whereas without it, the operation would clearly be a violation of the patient's constitutional rights.
They continue to state that: "The actions of the beneficiary of the right can have no influence on the invalidity of unconstitutional law or conduct. That is why a person cannot undertake to behave unconstitutionally. Such an undertaking will have no force and effect. Similarly a person cannot waive the indirect application of the Bill of Rights. Two persons cannot undertake for example, that the law of defamation must be applied in future disputes between them without any reference to the Bill of Rights... What individuals may do is waive the right

that he or she waives his or her right to vote, for instance, just as a person's decision not to pursue a delictual claim does not amount to a waiver of his or her right to bodily integrity. The court in *Cape Town Municipality and Another v Belletuin (Pty) Ltd*[41] observed that a waiver amounts to a voluntary relinquishment or abandonment of a right. Is it correct to regard the principle of *volenti non fit injuria* as a form of waiver especially in the case of the constitutional rights to bodily and psychological integrity? Another manner in which this concept is sometimes expressed is 'voluntary assumption of risk'. De Waal *et al* in their discussion on the question of waiver of constitutional rights[42] making a promising start but then seem to get hopelessly tangled up in the question of freedom rights as opposed to other kinds of rights, the question of whether in fact constitutional rights can be waived or whether the 'right to exercise a fundamental right' may be waived and the problem of the compartmentalisation of constitutional rights. It is the view of the author that there is very little if any practical distinction between a waiver of a constitutional right itself and the waiver of the right to exercise a fundamental right. The thinness of this 'distinction' it is submitted is likely to precipitate the very danger envisaged by Olivier J in the *Transnet* case[43] that a waiver of a right is a limitation thereof and that all forms of waiver, estoppel, acquiescence, etc could undermine the fundamental rights guaranteed in the Bill of Rights. He

---

to exercise a fundamental right. The individual may undertake not to invoke the constitutional invalidity of state or private conduct. However, from a constitutional point of view such a waiver is hardly even decisive of an issue. But it is also seldom irrelevant. While we deals with waiver here as an issue of application, we do not mean to suggest that it must be answered by simply asking whether the individual may exclude him or herself from the benefits of a particular fundamental right in the circumstances of the vase. Waiver and, more generally, victim responsibility, may also influence the limitation stage and the remedy that a court will award for breach of that fundamental right. The effect of waiver firstly depends on the nature and purpose of the fundamental right in question. In principle many of the freedom rights may be waived as long as the subject does so clearly and freely without being played under duress or misapprehension. For example the right to occupational freedom is often waived by employees when concluding a contract of employment. There is also not reason why one cannot waive the s14(d) right not to have the privacy of your communications infringed... In contrast to the freedom rights, the nature of the rights to human dignity (s10) to life (s11) and the right not to be discriminated against (s 9(3) and (4)) or the right to a fair trial, does not permit them to be waived. Unlike the freedom rights these rights do not have a positive and negative dimension. The right to freedom of expression for example can be exercised while keeping quiet but the right to dignity cannot be exercised by being abused. One cannot therefore assume that the right is exercised when it is waived as one does subject to some of the other considerations we have mentioned above, with the freedom rights. Although some rights may be waived, it does not mean that the fact of the waiver then becomes legally irrelevant. As stated above, waiver may also be relevant when considering the remedy to be awarded for the violation of a fundamental right.

41 *Belletuin* 1979 (2) SA 861 (A)

42 De Waal *et al* see fn 34 *supra*

43 *Transnet Ltd v Goodman Brothers (Pty) Ltd* fn 36 *supra*

points out that section 36(1) of the Constitution stipulates that 'the rights in the Bill of Rights may be limited only in terms of law of general application. . . .'. It is submitted that compartmentalisation of constitutional rights into freedom rights and other kinds of rights is also a dangerous argument since it does not take into account the fact that the Bill of Rights is a synchronous and internally consistent whole. One cannot separate out the right of freedom from the right to human dignity. One cannot separate the right to freedom and security of the person from the right to human dignity or the right to equality. The rights are a matrix of interrelated and interdependent concepts and to use methods of analysis which avoid this truth will ultimately lead to the reduction of the Bill of Rights to the sum of its parts rather than something more. This reduction will inevitably reduce the scope and significance of the underlying values of the Bill of Rights[44] and ultimately those upon which the Constitution itself rests. It is too mechanistic. Furthermore there is no need to rely on the dissection of the rights out of the Bill of Rights to this extent. The problem should be regarded rather in the light of a balancing exercise that is inevitably required not only of the judiciary in considering the rights of one party versus another or the executive in making policy decisions which may favour some rights over others but also of the individual in exercising his or her own rights in the infinite number of possible circumstances in which individuals in society find themselves. It is a matter of fundamental choices. This is nowhere more clearly illustrated than in the context of health services delivery. A patient who is in agony on his deathbed can exercise his right of access to health care services and to human dignity by requesting powerful painkillers that will inevitably shorten the duration of what life he has left to him. He is preferring his right to human dignity and access to health care services to his right to life. He would rather die

---

44 Section 7(1) of the Constitution states that the Bill of Rights enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom. Section 1 of the Constitution states that the Republic of South Africa is founded on the following values:
(a) Human dignity, the achievement of equality and the advancement of human rights and freedoms;
(b) Non-racialism and non-sexism
(c) Supremacy of the Constitution and the rule of law;
(d) Universal adult suffrage, a national common voters roll, regular elections and a multi-party system of democratic government, to ensure accountability, responsiveness and openness.

knowing and feeling that state of being human than to have a few more days of life as something less than human. He cannot have both under the circumstances. When a person gives consent to a surgical operation that he knows will violate his right to bodily and psychological integrity, he is choosing the right of access to health care services and possibly even the right to life and human dignity, depending on the reasons for the surgery, over the right to bodily and psychological integrity since under the circumstances, he cannot exercise these rights simultaneously. Even in dealing with the same right there are choices to be made. When a person asks to be sterilised he or she is exercising the section 12(2) right to make decisions concerning reproduction as much as when such person decides to have a child. This does not constitute a waiver of the constitutional right to make decisions concerning reproduction, it is an exercise of that right. When a person gives informed consent to be subjected to medical or scientific experiments he or she is exercising his or her right to bodily and psychological integrity, not waiving it. A person who chooses not to access health care services when they are freely available may be preferring his or her right to privacy and bodily and psychological integrity over the right of access to health care services. He is not waiving the latter. He may at any time change his mind. If for some reason he signs an agreement not to access external health services, because for instance he is participating in a clinical trial for which he is being paid and to which he has given informed consent, he has not necessarily waived his constitutional right of access to health care services. Indeed, the research organisation in question may in certain circumstances find that such a contractual provision means that it is completely responsible for the provision of all his health service requirements for the duration of the clinical trial. He may run the risk of being sued for contractual damages in seeking assistance for an urgent health care problem in breach of the contract but it is doubtful whether a court would uphold such a contractual term in most circumstances in which case the purported 'waiver' is likely to be nothing of the sort.

Outside of the health services context, it is submitted that even in the case of the more absolute rights in which the existence of choice is not *prima facie* evident, the element of choice is implicit in the enforcement of the right. Thus section 13 of the Constitution states that no one may be subjected to slavery, servitude or forced labour. If a person allows himself to be subjected to such and then takes the matter up in the Constitutional court, he or she is exercising his or her constitutional right in terms of section 13. It is extremely difficult to envisage any court allowing an argument that the person 'waived' his section 13 right by being subjected to slavery because the right reinforces the fundamental constitutional value of freedom. Even if the defendant successfully presents the argument that the plaintiff agreed to waive the right to exercise this constitutional right it is submitted that it is likely to meet with an unfavourable reception in a court of law. To allow such waiver would be to undermine a fundamental constitutional right and the underlying constitutional value of freedom. However, if a person subjects himself to slavery and does nothing about it, what external agency is going to take action on his behalf and in the absence of a request from him for assistance? Assuming that he is fully aware of his rights under section 13 and assuming that his decision to subject himself to what might be considered slavery is fully informed, he is in effect making a choice not to exercise his section 13 rights. In real life such a practical example is likely to be encountered in the context of certain forms of extreme religious beliefs which lead people undertake for instance join some form or religious order which requires them to devote their lives to working without pay or any other form of compensation. In such circumstances they would be preferring their right to religious freedom in terms of sections 15 and 31 of the Constitution over their section 13 rights. The criminal law is the vehicle through which society expresses its disapproval of certain actions and sanctions them but even at this level, someone has to take some positive action such as laying a charge or reporting the matter. Obviously the subject of religious cults is one of the more sensitive and controversial examples of the extent to which people

may exercise their constitutional rights but it serves as a useful illustration of the paradox of freedom.

An employee who is able to choose from a number of different posts but who decides on one in terms of which the employer requires a restraint of trade agreement because the employer feels the need to protect his own rights in the circumstances because it is much better paid than the others is exercising his right to freely choose his trade, occupation or profession, not waiving it. Such employee is also recognising his employer's right to protect his trade secrets i.e. his right to privacy. It is submitted that contracts involving constitutional rights and provisions which suggest that such rights are being waived are on the whole to be more soundly and sensibly construed as being attempts between private parties to regulate their relationship in terms of the same balancing exercise that the courts are often called upon to perform when disputes as to the validity of such contracts arise. Whether or not the balance such private parties eventually achieve is constitutionally acceptable remains for the courts to decide when the contractual relationship breaks down or when one of the parties changes her mind about the fairness of that balance.

The Bill of Rights is an indivisible web of concepts that cannot be construed or understood in isolation from each other. It is submitted that, the recognition of the need for consent in our law speaks to the constitutional value and right of freedom. Freedom in its turn is based upon the greater and more pervasive right to human dignity[45]. The nature of the right to freedom is not confined to physical freedom. Section 12(1)(a) of the Constitution refers to the right to

---

45 Thus in *S v Makwanyane And Another* 1995 (3) SA 391 (CC) the constitutional court stated that "Implicit in the provisions and tone of the Constitution are values of a more mature society, which relies on moral persuasion rather than force; on example rather than coercion. In this new context, then, the role of the State becomes clear. For good or for worse, the State is a role model for our society. A culture of respect for human life and dignity, based on the values reflected in the Constitution, has to be engendered, and the State must take the lead.
See also words of Mureinik E ['A Bridge to Where? Introducing the Interim Bill of Rights'] (1994) 10 *SAJHR* 31 at p 32: "If the new Constitution is a bridge away from a culture of authority it is clear what it must be a bridge to. It must lead to a culture of justification - a culture in which every exercise of power is expected to be justified; in which the leadership given by government rests on the cogency of the case offered in defence of its decisions, not the fear inspired by the force at its command. The new order must be a community built on persuasion, not coercion."

freedom and security of the person. This could be read in one of two ways. Firstly it could be read as meaning freedom of the person and security of the person. Secondly it could be read as meaning freedom generally and security of the person. The list that follows suggests that the former reading should be followed. However freedom is not only a right in the Constitution. It is a value as well. Consequently a broad interpretation of the concept of freedom must be followed when considering it in the context of the Constitution. Freedom cannot be seen in isolation from the other rights since the Bill of Rights is not merely a list of separate and independent rights but a complex web of interrelated and interdependent rights and freedoms in which the whole is more than the sum of its parts[46]. The constitutional court has said with regard to the apartheid regime and the multiple denials of freedom that occurred thereunder that:

"A feature common to all or many of these denials of freedom was a denial of the freedom to choose or develop one's own identity, a denial of the freedom to be fully human. One of the main objects of the Constitution is to eradicate such denial or restriction of freedom, not in a casuistic way but as a profound constitutional commitment."[47]

Significantly, the court emphasised the importance of not conflating freedom and the conditions of its exercise since in the process one could grant all the

---

46 Thus in *Ferreira v Levin No and Others; Vryenhoek and Others v Powell No and Others* 1996 (1) SA 984 (CC) Ackermann J held that: "An individual's human dignity cannot be fully respected or valued unless the individual is permitted to develop his or her unique talents optimally. Human dignity has little value without freedom; for without freedom personal development and fulfilment are not possible. Without freedom, human dignity is little more than an abstraction. Freedom and dignity are inseparably linked. To deny people their freedom is to deny them their dignity. Although freedom is indispensable for the protection of dignity, it has an intrinsic constitutional value of its own. It is likewise the foundation of many of the other rights that are specifically entrenched. Viewed from this perspective, the starting point must be that an individual's right to freedom must be defined as widely as possible, consonant with a similar breadth of freedom for others. There are other and more specific indications in the Constitution that the right to freedom is to be extensively interpreted. Section 35(1) embodies an injunction that, generally, in interpreting the chap 3 provisions, a Court of law must promote the values which underlie an 'open' and democratic society 'based on freedom and equality'. An 'open society' most certainly enhances the argument that individual freedom must be generously defined. It is a society in which persons are free to develop their personalities and skills, to seek out their own ultimate fulfilment, to fulfil their own humanness and to question all received wisdom without limitations placed on them by the State. The 'open society' suggests that individuals are free, individually and in association with others, to pursue broadly their own personal development and fulfilment and their own conception of the 'good life'. [Footnotes omitted] A teleological approach also requires that the right to freedom be construed generously and extensively." In footnote 34 of the judgment the court referred to the words of Isaiah Berlin's Introduction in *Four Essays on Liberty* :"Those who have ever valued liberty for its own sake believed that to be free to choose, and not to be chosen for, is an inalienable ingredient in what makes human beings human." Thus in constitutional terms the right of the patient in *Esterhuizen* (fn 19 *supra*) to freedom in the wide and general sense had been violated as much as had her rights to freedom and security of the person and to bodily and psychological integrity.

47 Ferreira fn 46 *supra*

freedoms in the world in the certain knowledge that the capacity or power to exercise them does not exist and that they are therefore meaningless[48].

For the purist, the doctrine of informed consent on the basis of *Esterhuizen*[49] may have a slightly different, or possibly less differentiated, basis than at constitutional law where, it is submitted, it would be based more appropriately on the right to bodily and psychological integrity in subsection (2) of section 12 as opposed the right to freedom and security of the person as contemplated in subsection (1) of that subsection. It is of interest that consent to the commission of a wrong is a unilateral juristic act which may be withdrawn by the consenting party at any time[50].

It has already been observed that in section 12 of the Constitution, the rights to freedom and security of the person are linked with those of bodily and psychological integrity. It is submitted that one of the reasons for this is that the personality must be construed as a whole. A violation of the right to freedom or security of the person will very often involve the violation of the rights to bodily or psychological integrity as well. This is supported by the fact that consent, in order to legitimate an action that would otherwise be wrongful in terms of the

---

48 In the words of Ackermann J in *Ferreira* fn 46 *supra:* "It is essential to distinguish between freedom (liberty) and the conditions of its exercise. It could be dangerous to conflate the two concepts. [and then quoting from Berlin 'Introduction' *Four Essays on Liberty*] - 'If a man is too poor or too ignorant or too feeble to make use of his legal rights, the liberty that these rights confer upon him is nothing to him, but it is not thereby annihilated. The obligation to promote education, health, justice, to raise standards of living, to provide opportunity for the growth of the arts and the sciences, to prevent reactionary political or social or legal policies or arbitrary inequalities, is not made less stringent because it is not necessarily directed to the promotion of liberty itself, but to conditions in which alone its possession is of value, or to values which may be independent of it. And still, liberty is one thing, and the conditions for it another... Useless freedoms should be made usable, but they are not identical with the conditions indispensable for their utility. This is not a merely pedantic distinction, for if it is ignored, the meaning and value of freedom of choice is apt to be downgraded. In their zeal to create social and economic conditions in which alone freedom is of genuine value, men tend to forget freedom itself; and if it is remembered, it is liable to be pushed aside to make room for these other values with which the reformers or revolutionaries have become preoccupied. . . . To provide for material needs, for education, for such equality and security as, say, children have at school or laymen in a theocracy, is not to expand liberty. We live in a world characterized by régimes (both right- and left-wing) which have done, or are seeking to do, precisely this; and when they call it freedom, this can be as great a fraud as the freedom of the pauper who has a legal right to purchase luxuries. Indeed, one of the things that Dostoevsky's celebrated fable of the Grand Inquisitor in The Brothers Karamazov is designed to show is precisely that paternalism can provide the conditions of freedom, yet withhold freedom itself."

49 *Esterhuizen* fn 19 *supra*

50 See *National Media Ltd And Another v Jooste* fn 27 *supra* in which the court referred to Strauss SA 'Toestemming tot Benadeling as Verweer in die Strafreg en die Deliktereg' (LLD thesis (1961)) at 199 and following and Neethling, Potgieter and Visser *Law of Delict* at p 90-1.

law of delict, must be freely and voluntarily given. Otherwise it does not qualify as consent for this purpose. Freedom implies an absence of coercion or constraint[51]. Despite some court decisions to the contrary,[52] until relatively recently there was some debate around awards of damages purely for mental suffering[53]. The court in *Clinton-Parker v Administrator, Transvaal Dawkins v Administrator, Transvaal*[54] noted that with reference to Bester's case, Burchell[55] correctly concluded that the previous approach had been regarded as too restrictive pointing out that Bester's case held that the brain and the nervous system is just as much part of the physical body as an arm or a leg. He stated:

'The Appellate Division in this case looked at certain limiting factors. The nervous shock in order to give rise to a claim for damages under the Aquilian action must be substantial and not of short duration and such shock must be reasonably foreseeable before the defendant can be held liable for causing such injury.'

The court commented[56] that as can be seen from Bester's case and subsequent developments, the erstwhile distinction between a psychological and physical injury has been rejected. In this sense mental injury has come to be regarded as much of a physical injury as more obvious bodily injuries.

The close link between the rights to dignity, freedom and security of the person and bodily and psychological integrity are demonstrated by the dictum of

---

51 *S v Lawrence; S v Negal; S v Solberg* 1997 (4) SA 1176 (CC)

52 *Waring & Gillow Ltd v Sherborne* fn 20 *supra* and *Hauman v Malmesbury Divisional Council* 1916 CPD 216

53 Burchell J in *Principles of Delict* at p 59 (as quoted by the court in *Bester* (see below) points out that the Courts 'here and in other countries have been cautious about extending liability for negligently caused nervous shock'. He points out that in the early cases in South Africa liability for negligently inflicted nervous shock was restricted by two factors, viz the nervous shock had to result in physical injury and the plaintiff must have feared for his or her own safety. Burchell states: "The first of these restrictions was based on the outdated distinction between mind and matter and based on the view that injury to the physical body was the subject of Aquilian liability and that damage to the individual's nervous system on its own was not sufficient for such liability. The second factor was a way of limiting the scope of potential liability to someone who in fact ran the risk of being physically injured.'
In *Bester v Commercial Union Versekeringsmaatskappy van SA Bpk* 1973 (1) SA 769 (A), the court stated that the reasonable foreseeability test was the test for liability for negligence and that this has repeatedly been set out in numerous authorities. He also pointed out that damages were regularly awarded for shock, pain and suffering, incapacity, loss of amenities of life and shortened life expectation, 'ten minste waar dit met 'n suiwer fisiese besering gepaard gaan'. He concluded that to deny a victim compensation purely on the basis that the shock and consequential harm were not allied to a physical injury cannot be defended logically.

54 *Clinton-Parker* 1996 (2) SA 37 (W)

55 Burchell fn 28 *supra* at p 60

56 *Clinton-Parker* fn 54 *supra* at p 68

Bosshof AJ in *Brenner v Botha*[57] where he stated that: "The specific interests that are detrimentally affected by the acts of aggression that are comprised under the name of injuries are those which every man has, as a matter of natural right, in the possession of an unimpaired person, dignity and reputation". They are all rights of personality under the common law[58].

In *Maisel v Van Naeren*[59] the court observed that:

"The foundations of the English and Roman-Dutch legal systems as to liability for delictual acts differ substantially. Speaking generally, all liability for delict in our common law derives from the application of the principles of the *actio injuriarum* and the *actio legis Aquiliae*, as they have developed through the centuries: and in terms of these principles blameworthiness on the part of the defendant, in the form of *dolus* or *culpa* as the case might be, is an essential in each case."

The concept of *dignitas* links the concepts of bodily and psychological integrity, dignity and freedom and security of the person[60]. There is also a strong link with

---

57 *Brenner* 1956 (3) SA 257 (T)

58 See also Gardiner, J.P., in *Rex v Holliday* 1927 CPD 395 at p. 400: "*Dignitas* is not simply the esteem in which a person is held by others - this is his '*fama*'- but it includes, it seems to me, his self-respect. Thus we find that writers on Roman Law include under *injuria* something more than violence to a man's person or his reputation. Moyle in his Institutes (l. p. 535) says: 'The delict of injury here treated may be defined as a wilful violation of what writers on jurisprudence term the 'primordial' rights of a free man - the rights to personal freedom, safety and reputation.' . . . de Villiers on Injuries (pp. 24 - 25) says: 'The specific interests that are detrimentally affected by the acts of aggression that are comprised under the name of injuries are those which every man has, as a matter of material right, in the possession of an unimpaired person, dignity and reputation. By a person's reputation is here meant that character for moral or social worth to which he is entitled among his fellow-men; by dignity that valued and serene condition in his social or individual life which is violated when he is, either publicly or privately, subjected by another to offensive and degrading treatment, or when he is exposed to ill-will, ridicule, disesteem or contempt. The rights here referred to are absolute or primordial rights; they are not created by, nor dependent for their being upon, any contract; every person is bound to respect them; and they are capable of being enforced by external compulsion. Every person has an inborn right to tranquil enjoyment of his peace of mind, secure against aggression upon his person, against the impairment of that character for moral and social worth to which he may rightly lay claim and of that respect and esteem of his fellow-men of which he is deserving, and against degrading and humiliating treatment; and there is a corresponding obligation incumbent on all others to refrain from assailing that to which he has such right.' The latter portion of this passage was referred to with approval by Innes, C.J., in *Rex v Umfaan*, 1908 T.S. at p. 67. It was because of this right to tranquil enjoyment, this primordial right of every man, that 'forcible and wrongful intrusion, into the house of another was looked upon as an injuria, not because it was a trespass on the property, but because it was a violation of family sanctity' (per Innes, C.J., loc. cit.). It is the violation of a man's rights of personality, his primordial rights of 'son état civile', which gives rise to an action of injury."

59 *Maisel* 1960 (4) SA 836 (C)

60 In *Jackson v SA National Institute for Crime Prevention and Rehabilitation Of Offenders* 1976 (3) SA 1 (A) the court noted that: "Dignitas embraces concepts of 'self-respect', 'peace of mind', 'mental tranquillity' and 'privacy'. Hunt, *S.A. Criminal Law and Procedure*, vol. II, p. 496, in considering the ambit of *dignitas* in relation to *crimen injuria* (which in this respect is similar to that in the *actio injuriarum*), specifies certain concepts falling under it, and then continues: "The concepts of self-respect, mental tranquillity and privacy are judged both objectively and subjectively. Objectively in that the law accepts that each person is entitled to them. Subjectively in that it depends upon the particular person and the circumstances whether it can be said that his dignitas has in fact been impaired. In a sense the quantum of dignitas varies from one person to another. An act which would not impair the dignitas of an ordinary person may conceivably impair the dignitas of a highly

the right to privacy[61] which it is submitted is inherent in the right to bodily and psychological integrity despite the fact that it also recognised as a separate right in the Bill of Rights. On the subject of damages for pain and suffering the courts have said in the past that such damages do not fall under the auspices of the *actio injuriarum* but under the *actio legis Aquilia*[62]. It is important to note,

---

sensitive person with whose known sensitivities the accused has deliberately trifled. Conversely, an act which would impair the dignitas of an ordinary person may in fact fail to disturb the complainant one iota; for instance, because she has expressly or impliedly consented to such conduct or because she is particularly broad minded and tolerant."

61 In Hunt P, *South African Criminal Law and Procedure*, vol. II, p 495, the author, after referring to attempts at definition and description of the word "*dignitas*" by the text-writers and the Courts, submits that it "is a somewhat vague and elusive concept which can, however, be broadly described positively in terms of a person's right to 'self-respect, mental tranquillity, and privacy.' These are the elements which have been constantly stressed by the courts. It can be described negatively in terms of his right to freedom from insulting, degrading, offensive or humiliating treatment and to freedom from invasions of his privacy".
In *S v A and Another* 1971 (2) SA 293 (T) the court held: "It seems to me that there can be no doubt that a person's right to privacy is one of, and I quote from Umfaan's case, "those real rights, those rights *in rem*, related to personality, which every free man is entitled to enjoy". Accordingly it appears to me that an infringement of a person's privacy prima facie constitutes an impairment of his dignitas. There have been many attempts in the authorities to define "dignitas". In Umfaan's case, on which Mr. Rosenzweig has relied, Innes, C.J. quoted the following passage: 'Every person has an inborn right to the tranquil enjoyment of his peace of mind, secure against aggression upon his person, against the impairment of that character for moral and social worth to which he may rightly lay claim, and of that respect and esteem of his fellow-men of which he is deserving, and against degrading and humiliating treatment; and there is a corresponding obligation incumbent on all others to refrain from assailing that to which he has such right.'
Further on he says: 'As affecting dignity, there are many illustrations. Insults to chastity, for instance, such as indecent proposals to a woman; forcible and wrongful intrusion into the house of another was looked upon as an injuria, not because it was a trespass on the property, but because it was a violation of family sanctity - of that peace and dignity which a free man was entitled to enjoy.'
Various other definitions are to be found collected in *South African Criminal Law and Procedure*, formerly *Gardiner and Lansdown*, in vol. 2, which is by Hunt, at p 495. I do not think it necessary to refer to the various definitions of this concept as set out in this work. Suffice it to say that I have no doubt that the right to privacy is included in the concept of dignitas, and that there is no dearth of authority for this proposition."

62 Thus the court in *Hoffa, No v SA Mutual Fire & General Insurance Co Ltd* 1965 (2) SA 944 (C) held that it would be wrong, both historically and in principle, to classify a claim for damages for pain and suffering, etc., under the *actio injuriarum*; (a) The *actio injuriarum* requires an *animus injuriandi*, whereas this claim (like any other Aquilian relief) can be based on mere *culpa*. See *Matthews v Young, supra*; de Villiers, loc cit. (b) This claim can be ceded, whereas a claim under the *actio injuriarum* is incapable of cession. De Villiers, loc cit; Sande De. Act. Cess. 5.11 (Anders' translation, p. 58), and see *Botes v Hartogh*, 1946 W.L.D. 157; *Walker v Malterson*, 1936 NPD 495. (c) The *actio injuriarum* always incorporates an element of *contumelia*. See *Stoffberg v Elliott*, (fn 18 *supra*) 148; *Matthews v Young, supra*, whereas this is not included under 'pain and suffering', see *Radebe v Hough*, 1949 (1) SA 380. Mental shock is not actionable under the *Lex Aquilia*. See *Hamman v Malmesbury* D.C., 1916 CPD 216; *Layten & Layten v Willcox & Hissinson*, 1944 S.R. 48. (d) The *actio legis Aquiliae* was extended - even in Roman law - to cases of bodily injury. See *Matthews v Young, supra*; *Union Government v Warneke, supra*; Voet, 9.2.11, 47.10.18; van den Heever, op. cit. (e) The *actio injuriarum* constituted an exception to the rule as to transmissibility. See McKerron on *Delict*, 6th ed. p 131; Buckland, pp. 313, 586, 685 - 6; de Villiers, p. 235. (f) Claims for pain and suffering, etc., are merely factors in the assessment of the quantum of the *damnum*. See *Coetzee v S.A.R. & H, supra*. See also *Sandler v Wholesale Coal Supplies*, 1941 AD at pp 194, 199. As to what this damnum can comprise, see the authorities collected in Gordon & Suzman *Law of Compulsory Motor Vehicle Insurance*, p. 99. In our law the *actio legis Aquiliae* is no longer penal, but reipersecutory, whereas the *actio injuriarum* is purely penal. McKerron, op. cit, pp. 7 - 9. (g) The *actio injuriarum* is not associated with bodily injury, but with injured feelings where no physical hurt has been done. See *Pauw v African Guarantee*, 1950 (2) SA 132. (h) It would be anomalous in a case of bodily injury to allow certain claims - such as for loss of support, see *Union Government v Lee, supra*, and loss of earnings, see Lockhat's case, *supra* - to survive the death of the injured person, and others not."
In *Government Of The Republic Of South Africa v Ngubane* 1972 (2) SA 601 (A), counsel for the respondent pointed out that "The claim for pain and suffering in respect of an injury to a freeman was unknown to the Roman civil law or to the *actio legis Aquiliae*: Hoffa, supra at pp. 950F, 951E; D. 9.1.3; D. 9.3.7. The Roman-Dutch law allowed an action for pain and suffering but this did not have its roots in the Aquilian action although it was often brought at the same time. It could not form part of the Aquilian action because the Aquilian action lay only for patrimonial loss. Hoffa, *supra* at pp. 950H to 952F; *Union Government v Warneke*, 1911 AD at p.

however, that this is a historical legal anomaly since in Roman Law, only patrimonial damages were recoverable under the *Lex Aquilia*[63]. Damages for

---

662; Van den Heever, Aquilian *Damages in South African Law* at p. 35; *Gillespie v Toplis*, 1951 (1) SA at p. 296; *Matthews and Others v Young*, 1922 AD at pp. 503 - 5. In contrast to the Aquilian action, the *actio injuriarum* was incapable of active or passive transmission or cession before litis contestatio, it being regarded as purely personal to the victim. Hoffa, *supra* at p 950G; *Executors of Meyer v Gericke*, 1880 Foord 14; *Pienaar and Marais v Pretoria Printing Works*, 1906 T.S. 654. Since the claim for pain and suffering is sui generis and not an Aquilian action, the Aquilian rules do not apply to the cedability of such a claim and we have to look elsewhere for guidance. (a) The general rule of our law is that, if a claim is based on lex Aquilia, it is actively transmissible and may be freely ceded, but if it is based on or analogous to the actio injuriarum, it is not actively or passively transmissible or capable of being ceded, certainly up to the stage of *litis contestatio. Regering van S.A. v Santam Versekeringsmaatskappy Bpk.*, 1970 (2) SA 41.Damages for pain and suffering are claimable under the *lex Aquilia*, this being a recognised exception to the rule that in a claim under the lex Aquilia the plaintiff has to show actual patrimonial loss. *Union Government v. Warneke*, 1911 AD at pp. 665 - 666; *Coetzee v S.A.R. & H.*, 1934 CPD at p. 226; *Schnellen v Rondalia Assurance Corporation of South Africa*, 1969 (1) SA at p. 520D - H; Voet, 9.2.11 (Gane's trans. vol. 2, pp. 561, 564) (and cf. Grotius, 3.34.2; Vinnius, ad Inst., 4.3.13; Groenewegen, de Leg. Ab. ad Dig., 9.3.7); Lee and Honore, *S.A. Law of Obligations*, para. 763 (ii)." The lines between an injury to *dignitas* under the actio injuriarum and a personal injury under the lex Aquilia are not, however, as clear cut as the previous dicta might suggest. It is of some significance that even at a time when the compartmentalisation of legal concepts was the order of the day, the court also stated that: "The damages for pain and suffering are analogous to the *solatium* allowed by the *actio injuriarum* for injured feelings and the claim for pain and suffering has the same personal and non-patrimonial basis as *the actio injuriarum. Regering van S.A. v Santam Versekeringsmaatskappy Beperk, supra* at p. 43A; Hoffa, *supra* at pp. 954E, 955C; Sande, chap. 5, para. 12 (Sande's trans., p. 63); *Stewart's Executrix v L.M.S.*, 1944 S.L.T. 13. The Roman-Dutch authorities were against granting compensation for pain and suffering to those who did not suffer the injury. Voet, 9.2.11, 27. See also Melius de Villiers, *Roman-Dutch Law of Injuries*, pp. 235, 238."
The court seems to have concurred with this exposition of the law on behalf of the respondent since at p606 of the judgment it observes that as to the Roman and the Roman-Dutch law, the position is in my view appropriately summarised at p. 33 of the typescript of a lecture delivered to the University of Edinburgh by Professor J. C. de Wet, of Stellenbosch University. Tracing the history of liability for wrongful conduct, the learned author says - 'In Roman law, as we have seen, a free man, who had been wounded, could claim medical expenses and loss of earnings from the male-factor, but no claim was allowed for scars and disfigurement, the reason being that the body of a free man had no monetary value. This rule was retained in mediaeval secular law and also in the Canon law. Our Roman-Dutch institutional writers are, however, unanimous in allowing the victim of bodily injuries not only his medical expenses and loss of earnings but also a claim for pain and suffering (dolor) and disfigurement (cicatrix, deformitas). See Grotius, Inl., 3.34.2; Vinnius, Ad. Inst., 4.3.13; Groenewegen, De legibus abrogatis, ad D., 9.3.7... Voet, 9.2.11. That a claim for pain and disfigurement was an anomaly in a system which was supposed to know only 'actiones reipersecutoriae' cannot be contradicted. Grotius realised this and admits that (Inl. 3.34.2)... pain and disfigurement (are) really not capable of compensation. This claim was undoubtedly bound up with the composition payable in terms of local customary laws, based on Teutonic tribal laws, by the person who had caused bodily injuries to another...' It follows from the foregoing that it is inappropriate to try to bring such a claim under the umbrella of either the actio legis Aquiliae or the actio injuriarum. I agree, with respect, with the view to this effect expressed by Van Winsen J., in *Hoffa, N.O. v S.A. Mutual Fire & General Insurance Co. Ltd.*, 1965 (2) SA 944 (C) at p. 952F, and the penultimate sentence. And the learned author, just referred to, correctly adds thereanent: 'Regter Van Winsen het dus heeltemal gelyk waar hy in Hoffa se saak sê dat mens by aanspreeklikheid vir pyn en leed nog met injuria nog met damnum injuria datum te doen het.' Continuing the examination of analogous material within the fabric of our law, I cite the fact that in the Hoffa case Van Winsen J., in a considered and convincing judgment, comes to the conclusion, at p. 953D, that 'in general, the Roman-Dutch law only recognised as being transmissible to a deceased's heirs those claims in respect of wrongs causing a diminution in the patrimony of the deceased's estate, which would of course exclude claims in respect of pain and suffering and loss of amenities'."

63 See *Southern Insurance Association Ltd v Bailey No* 1984 (1) SA 98 (A) in which the Appellate Division noted that: "Our Courts have awarded damages for pain and suffering, disability and loss of amenities on one of two bases. In one line of decisions, in which the sui generis nature of the action for pain and suffering from its Germanic roots are noted, damages awarded thereunder are treated as in a certain sense analogous to the solatium claimed under an actio iniuriarum. *Hoffa v SA Mutual & Fire General Insurance Co Ltd* fn 57 *supra* at 955A; *Potgieter v Rondalia* 1970 (1) SA at 712G - H; *Regering van RSA v Santam Versekeringsmaatskappy* 1970 (2) SA at 43B; *Government of RSA v Ngubane* 1972 (2) SA at 606E - G 607B. In other decisions, emphasis has been placed on a functional approach to the assessment of damages for non-pecuniary loss. *Geldenhuys v SAR & H* 1964 (2) SA at 235C; *Steenkamp v Minister of Justice* 1961 (1) PH J9; *Pretorius v Geldenhuys* (Corbett and Buchanan (op cit at 805)); *Gonya v Rondalia Assurance Corporation* (Corbett and Buchanan (op cit vol 2 at 311)); *Marine & Trade Insurance v Katz* 1979 (4) SA at 983E - G." The court seemed to prefer the latter approach because it "leads to fewer anomalies and has been successfully applied in four cogent recent judgments of the Supreme Court of Canada."

pain and suffering were equally not recoverable under the *actio injuriarum*. They were recoverable under a separate action altogether but have since been grafted on to the Aquilian action.

8.2.4 Dube v Administrator Transvaal[64]

Facts

The plaintiff attended on 26th June 1961, at a provincial hospital after he had been assaulted the night before and sustained two blows to his left forearm. An X-ray revealed a comminuted fracture of the ulnar bone of the upper forearm near the elbow. The arm was set in plaster. He attended again on 28th June and at that time the hospital's medical practitioner had considered the cast satisfactory. On 3rd July he again saw the medical practitioner at the hospital. The hand was grossly swollen and septic with loss of movement in the fingers. He was then admitted to hospital and treated for sepsis of the hand until 13th July. In January 1962, his arm had to be amputated. According to the medical evidence the plaintiff had sustained a Volkmann's contracture. A Volkmann's contracture is liable to occur with a fracture at or near, especially just above, the elbow joint, and particularly where it requires manipulation for setting or setting the arm in plaster or splints at an acute angle. It is a rare occurrence. Statistics were quoted from an article in vol. 103 (1956 (2)) of the Journal of Surgery, Gynaecology & Obstetrics, showing that the incidence amongst arm fractures treated at the Mayo Clinic in America prior to 1935 was .18, and between 1935

It continued by saying that: "A strict functional approach should have been adopted. See *Lindal v Lindal* (*supra* at 29 - 30). On this approach, the child's lost faculties are priceless (cf *Sandler v Wholesale Coal Suppliers* 1941 AD at 199). The focus does not fall on an evaluation of her loss, but on her distress and the uses to which money might be put to alleviate that distress and misery. The present case is palpably not an instance where a large award would serve to assist the child by the purchase of special equipment, entertainments or physical facilities. Compare *Marine & Trade Insurance Co Ltd v Katz NO* 1979 (4) SA at 983B - G. In view of the s 21 (1C) (a) undertaking given, there is in any event the danger of overlapping in this regard too. Even if damages for pain and suffering and loss of amenities are to be awarded in the present case as a *solatium*, then the Court is to be concerned with "a fair social value" which is "the dispassionate and neutral value which society at large, on the basis of prevailing money values in that society, would give to it". Munkman (op cit at 18,21). In making such assessments, our Courts have emphasised the application of the principles of conservatism and fairness, and the importance of comparable awards in this regard."

64 *Dube* 1963 (4) SA 260 (W)

and 1954, .08 per 1,000. Within the knowledge of the medical specialist who gave evidence for the defendant, the plaintiff's was the first case that had occurred at the Hospital in 2,000 cases of arm fractures. Notwithstanding that, Volkmann's contracture is a well-known condition. The possibility of its occurring and developing is stressed in the ordinary course of teaching surgery and it should therefore be known to all practitioners. The signs of such a condition usually manifest within 48 hours of the originating cause but often within a lesser time. The court found on the evidence that the Volkmann's contracture began before 28th June and had become irreversible by the 3rd July. It held that the probable cause was that the plaster was applied too tightly, but that arterial thrombosis or damage could not be ruled out as an additional cause.

The court held that the hospital was liable in the law of delict for damages. It said that the plaintiff's failure to return when the swelling started was attributable to the hospital's failure to warn the plaintiff clearly and unambiguously to return immediately any abnormal symptom was manifested. The plaintiff thus reasonably assumed that the persistence of the pain and the swelling he noticed were occurring in the ordinary course of healing and were not danger signs that he might lose the use of his arm if not attended to immediately. Consequently, said the court, the plaintiff had not been guilty of any contributory negligence in not returning until the 3rd July and that no apportionment of damages need be made.

Judgment

The plaintiff's action was founded in delict and not on contract. The court noted that because the hospital accepted the plaintiff on the 26th June as a patient its staff owed him a duty to attend to and treat him with due and proper care and skill. The court stated that it was immaterial whether he was a paying or non-paying patient. The duty that was owed was to exercise that degree of care and skill which the reasonable plasterman and general medical practitioner

respectively would ordinarily have exercised in South Africa under similar circumstances. Any breach of that duty would constitute negligence. It held that the doctors treating the plaintiff were negligent in one or more of the following respects:

(1) applying the plaster initially too tightly;

(2) failing to diagnose the possible onset of a Volkmann's contracture on the 28th June, and to take other measures to arrest the development of the Volkmann's contracture;

(3) failing to give the plaintiff on the 28th June a clear and unambiguous instruction and warning to return immediately if the pain persisted and/or swelling developed in the hand and fingers.

The court pointed out that a mistaken diagnosis is not necessarily a negligent diagnosis. It may be due to a reasonable error of judgment but said that it did not think that Dr. Wolf's failure to react in the proper manner to the plaintiff's complaint of pain in the hand and fingers on the 28th June was a mere error of judgment, even having regard to the pressure under which she had to work. According to the expert medical evidence on such a complaint of pain being made the reasonable general practitioner exercising ordinary skill and care, would have removed the plaster and taken other precautionary measures. If that had been done on the 28th June the plaintiff's limb would have been saved. The court held that Dr Wolf was therefore negligent in that respect. The court, quoting from Nathan *Medical Jurisprudence*[65] and saying that his observations are so apposite that they were worth quoting in full, acknowledged that the

---

65 Nathan B *Medical Jurisprudence* who states at p 46: "In many cases it is reasonable or even necessary for the medical man to make the patient himself responsible for the performance of some part of the treatment which the medical man has undertaken to give. Where, as often happens, the medical man's course of action depends upon a report by the patient as to his condition or symptoms or as to the progress of the treatment, the medical man has no choice in the matter; he must rely upon the patient for the necessary information by which to determine what action should be taken, and must therefore, in a sense, delegate to the patient part of his own duties. Frequently also it would be quite unreasonable to expect the medical man to be in constant attendance upon the patient or to exercise supervision over every detail of the treatment; he is compelled therefore to delegate to the patient the performance of some part of the treatment or cure... In all these cases where the medical man justifiably delegates to the patient the performance of some part of the treatment, there is a special duty towards the patient to give clear and unambiguous instructions, to explain to the patient in intelligible terms what is required of him and to give him any warning which may be necessary in the circumstances; and a failure in any of these respects may amount to a breach of duty and expose the medical man to liability for any injury which occurs."

patient can reasonably be required to take care of himself or take responsibility for some aspects of his treatment in certain instances since the medical practitioner cannot be expected to do everything that is necessary for the patient's care. The court also referred with approval to a dictum in a Canadian case[66] which suggested that the failure of a medical practitioner to warn a patient could in certain circumstances constitute negligence on the part of the practitioner. It observed that there was a special duty owed by the hospital, through its servants, to the plaintiff to give him clear and unambiguous instructions as to what he was to do. The plaintiff should have been carefully instructed to watch out for any swelling, pain, blueness or numbness of the hand and fingers and to return (and the need to do so should have been stressed) immediately any such symptoms manifested itself because each would have been a danger sign. The court held that he should also have been warned of the possible consequence of not obeying such an instruction implicitly, namely, of losing the use of his forearm and hand. Trollip J stated that a plaintiff is generally not guilty of contributory negligence if his ostensible lack of care for his own health or safety was caused by the conduct of the defendant which induced or misled him to believe or assume reasonably that his action or inaction would not endanger his health or safety.

Discussion

It is submitted that this case does not support medical paternalism in regarding as negligent the failure of the health services provider to warn the patient concerning certain danger signs and symptoms. The court expressly acknowledged in fact that a health care provider cannot take responsibility for every aspect of a patient's care and that the patient himself must take some

---

66 *Murrin v Janes*, (1949) D.L.R. 403 in which the court held: "I am prepared to believe that in some kinds of cases, particularly in this domain of medicine and surgery, the failure by a doctor or a surgeon to warn a patient as to the meaning of certain symptoms, the significance of which might not be apparent to a layman, might properly expose a practitioner to a charge of negligence. The physician cannot always be in constant attendance upon his patient, who may have to be left to his own devices; and if the former knows of some specific danger and the possibility of its occurring, it may well be part of his duty to his patient to advise him of the proper action in such emergency."

responsibility for certain aspects. It is noteworthy that Trollip J also pointed out that not every mistake in diagnosis amounts to negligence. The nub of this case revolves around the fact that the health care provider, a person with expert skill and knowledge, applied a plaster cast to the patient's arm after he sustained a serious injury and failed to tell him of the dangers posed by such a cast when used in conjunction with an injury such as the one he had sustained. The patient was not in a position to have this knowledge as it is not generally known outside of the medical profession and the health care provider in assuming the risk of treating the patient put itself in such a relationship to the patient that it was obliged to exercise a certain degree of care and skill as was required of a reasonable person in the defendant's position[67]. A reasonable medical practitioner would not only have warned the patient about certain danger signs and told him to come back if he noticed them but also would have explained what would happen if he did not immediately seek medical attention. There was a duty upon the provider to ensure that the patient understood the risks to which he had been exposed not only by the injury itself but also the subsequent treatment of it. It is submitted that this is due to the superior position of the provider in terms of knowledge and expertise in relation to that of the patient. The patient, with insufficient medical knowledge, would be likely to assume that now that he has been treated by the experts, the situation is under control and he is on his way to recovery. He is unconsciously relying on the fact that the people who treated him are experts and that they know what is necessary for his recovery. It is submitted that this is reasonable behaviour upon the part of the patient since the people who treated him publicly professed to have the necessary knowledge and skill. They were registered health professionals who had been found by a council of their peers to be suitably qualified and skilled to pursue their professions. This is the reason why in order to transfer the risk for certain aspects of his treatment back to the patient, they had to share with him

---

67 Trollip J cited van *Wyk v Lewis*, (fn 24 *supra*) at p 444, p 456 and *Esterhuizen v Administrator of Transvaal*, (fn 19 *supra*) at p 723 C to E, p 726 A to C as authority.

the knowledge they had concerning his condition in such as way that he could himself appreciate the risks involved.

The court held that whether or not the patient was a paying patient or a non-paying patient was of no relevance. The implication to be drawn from this is that even if there is a contractual overlay to the relationship, the duty of care, from a delictual perspective remains unchanged. Dube's case[68] involved a negligent omission and vicarious liability since the doctor in question was an employee of the state.

The court did not expressly address the question of vicarious liability[69] although it is clear from its finding that it regarded the employer as vicariously liable as much for the negligent omissions of its employees as for their negligence in applying the plaster cast too tightly. With regard to liability for negligent omissions the court simply referred to the dicta in the Canadian case referred to by Lord Nathan - *Murrin v Janes*[70].

The court also referred to the case of *Clarke v Adams*[71] with regard to the need to warn the patient not only that he must take care to watch out for certain danger signs and signals but also of what will happen if he does not. In that case a physiotherapist, about to give a patient diathermy treatment, gave him the following warning: 'When I turn on the machine I want you to experience a comfortable warmth and nothing more; if you do, I want you to tell me.' The patient did not report that the heat was excessive and was badly burned necessitating the amputation of his leg. It was proved that such a warning was the usual one according to ordinary practice, but Slade J., held that it was not sufficiently clear and unambiguous in its terms to warn the patient of the danger

---

68 *Dube* fn 64 *supra*

69 Except to observe that it was not disputed that the Hospital was liable for any negligence by those of its servants who treated and attended to the plaintiff.

70 *Murrin* fn 66 *supra*

71 *Clark* (1950) 94 S. Jo. 599

and consequences of excessive heat, and that the physiotherapist had therefore been negligent in not giving an adequate warning. Similarly, said Trollip J, the plaintiff should also have been warned of the possible consequence of not obeying an instruction implicitly, namely, of losing the use of his forearm and hand. He said that the very fact that in the hospital's experience so many patients with fractures do ignore instructions to return, indicated the need, in cases of fractures at or near the elbow with their concomitant risk of a Volkmann's contracture, to give not only the instruction to return if abnormal symptoms are observed but also to impress upon each patient the risk he runs of failing to do so.

A further point to note about the judgment in *Dube* is that the court held that a plaintiff is generally not guilty of contributory negligence if his ostensible lack of care for his own health or safety was caused by the conduct of the defendant which induced or misled him to believe or assume reasonably that his action or inaction would not endanger his health or safety. It is submitted that the public policy principle behind this line of reasoning is that the imbalance between the provider and the patient in terms of knowledge and skill, needs to be recognised. The greater the disparity in knowledge between the patient and the provider, the greater the responsibility of the provider to ensure that the patient is sufficiently and correctly informed. In other words there is a duty on the provider to reduce the knowledge gap between himself and the patient sufficiently to discharge his (the provider's) duty of care. If one follows this line of reasoning through to what seems to be its logical conclusion one might be tempted to conclude that the more informed a patient is the less risk the provider carries so that ultimately a patient who is as informed as the provider, carries the risk for his treatment himself and the provider bears none. A factual example of such a case would be where an orthopaedic surgeon requires orthopaedic surgery. Obviously he cannot conduct the surgery himself and must seek the aid of another orthopaedic surgeon. It is submitted, however, that whilst they may discuss in greater detail the specifics of the operation and even the best surgical methods, pins and

screws etc to use, the responsibility for the operation still rests on the orthopaedic surgeon performing it. The reason for this is that the patient, although an orthopaedic surgeon himself, is under anaesthetic at the time of the operation and so is not in a position to actually see the true state of the injury or to know exactly what was done to repair it. If one assumes that the nature of the injury in this example is such that it could lead to a Volkmann's contracture, one might be tempted to say that the extent of the duty of the orthopaedic surgeon who did the operation to warn the patient of the danger of a Volkmann's contracture developing is reduced by the patient's own expertise in this field.

The question, however, is to what extent a provider of health care services would be entitled in the context of the law of delict to assume knowledge on the part of the patient. Patients are people who are usually in pain, who are often not operating optimally mentally due to stress, medication and physical discomfort. They may be suffering from post traumatic stress syndrome or other psychological fallout from their injury which makes them forgetful. Even if they do have knowledge beyond that of the average layperson when it comes to their condition, it is submitted that it would be dangerous for the provider to assume that they are in a position to retrieve and apply that knowledge to their own situation. It would also be dangerous for the provider to assume the extent of that knowledge. It is submitted that to the extent that the provider fails to inform even an expert patient of the risks and dangers associated with his condition and the treatment thereof, he runs the risk of delictual liability. A court may more readily find that there was contributory negligence in such a situation but there is still a measure of risk for the provider and it is quite possible that even though the patient does have a certain amount of expertise in a particular area, he may not know everything there is to know about it.

The court held that the plaintiff in *Dube* was not guilty of any contributory negligence and decided the case in his favour.

8.2.5 S v Mkwetshana[72]

Facts

The appellant, a medical practitioner, was convicted by a regional magistrate of culpable homicide. At the time of the incident in question he was serving his internship for the 12 months succeeding his qualifying in his profession. He was serving his internship at Edendale Hospital. Previously he had been a student at the medical school of the University of Natal, and had attended King Edward VIII Hospital in Durban during the course of his studentship. In March, 1964, a woman named Alice Nduli who suffered from bronchial asthma was a patient in Edendale Hospital for a short time. At first, she was an out-patient and then became an in-patient for a few days. When her condition improved she was discharged. There were difficulties in returning to her home immediately, because she lived some distance from the hospital, and so she remained a patient over Good Friday, 27th March. On the morning of that day, a staff nurse, Florence Kunene, noticed that the patient was in a distressed condition and that her breathing was bad. The appellant was called. He was apparently the only medical officer available in the vicinity at the time although it was not clear whether he was the only medical officer in the whole hospital, or the only one in that part of the hospital. According to the appellant, when he came to the patient he found her restless, lying on her back, kicking her feet and throwing her arms about. On closer examination he found her lips and tongue were bluish and she was also frothing at the mouth. He diagnosed a severe acute form of asthma and ordered 20 cc's of aminophylline - a recognised drug for treatment of asthma. He said that he administered this intravenously and waited for some five to seven minutes, but that, contrary to what one would expect, it did not relieve her condition. The medical evidence called for the prosecution showed that aminophylline does function quickly, it may be that even during the course of

---

72 *Mkwetshana* 1965 (2) SA 493 (N)

its administration signs of improvement will be seen in the patient. The appellant said that five to seven minutes elapsed and there was no improvement. He then thought that this might be epileptic convulsions which were not previously diagnosed and he consequently decided to treat her with paraldehyde. The appellant ordered and administered 20 cc's of this drug intravenously. He watched the patient and said that her condition improved. However the patient died shortly afterwards. The staff nurse said she died about 15 minutes after the administration of the paraldehyde. The appellant was prosecuted and convicted of culpable homicide, and sentenced to a fine of R50 or 25 days' imprisonment.

Judgment

The court noted that a dose of 20 cc's of paraldehyde intravenously was an excessive dose. The evidence showed that there were four routes for the administration of the drug, namely, orally, by intramuscular injection, intravenously and per rectum, and that the dose varied according to the route. It observed that the particular feature of intravenous administration of the drug is that it operates with considerable rapidity because it is injected into the bloodstream, and the recognised dose is no more than 5 cc's, and even so, diluted in the proportions one to ten with saline - a sodium chloride solution. The appellant administered the drug in a dose of 20 cc's without any dilution, and counsel for the defendant conceded that that was a fatal dose and that it would have caused the death of the deceased.

It was contended on appeal that the state failed to prove that the death of the deceased was due to the administration of paraldehyde. Counsel for the accused argued that the state had the burden of proving the cause of death beyond all reasonable doubt - of proving that this, on the evidence, was the administration of paraldehyde, to the exclusion of any other possibility, beyond all reasonable doubt. Counsel emphasised that the appellant himself diagnosed the case to be

one of epilepsy and that this was after he had found that the aminophylline had not done what was expected of it. During the course of the deceased's presence in hospital she had been put through various tests and it had been found that her serum sodium level was low which suggested the possibility of her having some condition other than bronchial asthma, but it was at no time ascertained that she had any such disease. Nothing further was done to follow up that line during the course of the time that she was in the hospital, and nothing found in the post-mortem examination, conducted a week after her death, disclosed any condition likely to have caused her death other than paraldehyde poisoning.

Counsel for the accused argued that the district surgeon who conducted the post-mortem examination commenced that examination with a predilection in favour of finding paraldehyde poisoning to be the cause of death. He said in evidence that this was given as a suspected paraldehyde poisoning because of the signs pointing to it. Counsel emphasised, however, that the district surgeon had his mind specifically directed to that as the possible, if not probable, cause of death and that consequently, his mind was not directed, as otherwise it might have been, to finding some other cause of death. It was argued that the reasonable possibility that death was due to convulsions or epilepsy has not been excluded. The court noted that the district surgeon did say in clear terms that no findings pointed to the patient having died of a convulsion, and that was a strong piece of evidence negating the possibility raised by counsel for the accused. The court noted that the appellant made a statement on oath on the same day as the post-mortem examination was made. It was a short and abrupt statement that did not elaborate upon what he found and was to the effect that he found the patient restless and dyspnoeic. The accused mentioned the bronchial condition in both lungs and stated that he diagnosed acute bronchial asthma and proceeded to treat the patient as follows, as he then sets out: "(a) 20 cc. aminophylline statim intravenously, plus (b) 20 cc. paraldehyde statim intravenously" as having been given by him.

The court stated that it was significant that he made no mention there of any convulsions or of epilepsy. It acknowledged that he did speak of the patient being restless, but commented that he did not seem to have regarded it as so significant when he made the statement as to suggest that the cause of death was epilepsy, convulsions, or anything other than paraldehyde poisoning. The accused made no statement as to the case of death. The court said that whilst epilepsy can attack at any time, and that there was a possibility that the deceased had epilepsy, there was no evidence from which to draw the conclusion that there was a reasonable possibility of this. It noted that the fact that he administered paraldehyde suggested that he considered the situation to be an emergency and that some remedy of that nature was required for a condition which must have seemed to him to have involved something other than bronchial asthma, because the evidence disclosed that paraldehyde would not be administered for that condition. The court was unable to accept the possibility that epilepsy was the cause of death. It concluded that the magistrate was correct in his finding that this was a case of paraldehyde poisoning, due to the administration of the excessive dose by the appellant.

Counsel for the appellant contended that the administration of paraldehyde by the appellant was not negligent in the circumstances. He relied on the fact that the appellant was an intern, comparatively inexperienced and alone on duty at the time when he was confronted with an emergency. It was argued that he did the best that he could in that emergency, bearing in mind his own limited experience. Counsel referred to the decision in *R v van der Merwe*[73] and the summing up of Roper J, to a jury relating to the tests for negligence on the part of a general practitioner in comparison with the test for a specialist.

The court commented that either the appellant knew insufficient about the drug and, nevertheless, took the risk - and imposed on his patient the risks involved in it - or he was aware of the risks and that it was a dangerous drug to use in the

---

73 *Van der Merwe* fn 3 *supra*

manner in which he was using it, in which case, equally, he would be guilty of negligence. It noted that counsel for the accused would have the court say that because of his inexperience it should not be held against him that he administered a potentially dangerous drug, in a manner which made it dangerous, but said that it was clear that for the accused to have done that, in the light of his inexperience, and particularly his inexperience of this drug and its uses, marks him as having been negligent. The court stated that it was clear from the evidence that the information as to the proper uses of the drug was freely available. Several text-books were referred to in evidence, including text-books which are in use by students during the course of their medical courses, and there was no excuse for a medical man, even though just setting out on his career, that he neither knew those doses and uses, nor troubled to have them available to him. The court observed that although the appellant was alone, at any rate in that part of the hospital, it was not impossible for him, in the circumstances, to have made communication with someone senior to himself. He waited some five to seven minutes while he was watching the patient and in that time, seeing that she was not improving, it was possible, for him either to have telephoned or to have sent a staff nurse for assistance. However, he did none of those things, nor did he refer to any text-book. Knowing nothing from his experience, and recollecting nothing from his training, he administered the drug in a quantity and in a manner which was dangerous for the patient, and indeed caused her death. Consequently said the court, in those circumstances, the appeal failed.

Discussion

This case is consistent with the decision of the court in *R v van Schoor*[74]. It reinforces the legal precedent created by the latter. If one attempts a task for which one does not have the requisite knowledge, training or skill, one assumes the risk of adverse consequences arising from such lack of training, knowledge

---

74 *Van Schoor* fn 1 *supra*

or skill. It is submitted that it is based upon the same public policy rationale that imposes liability for consequential damages for latent defect under the law of contract in a situation in which the seller sells goods of his own manufacture or goods in relation to which he publicly professes to have attributes of skill and expert knowledge. The patient cannot assess the level of skill or experience of the health professional. The latter by definition publicly professions to have attributes of skill and knowledge in the delivery of health care services. It is therefore fitting in terms of public policy that the patient or the consumer should be given the benefit of the doubt in such circumstances. Although these cases predate the Constitution it is submitted that their findings are consistent with constitutional values and principles. The constitutional right to bodily and psychological integrity is closely related to the right to freedom and security of the person. The former is expressed in subsection (1) of section 12 of the Constitution while the latter is expressed in subsection (2). In both subsections the list of rights in these categories is not exhaustive due to the use of the word "includes" which precedes the lists. It is submitted that in the context of health care services in particular the potential for infringement of these rights is the norm rather than the exception due to the nature of health services. Consequently people professing to be experts in the rendering of those services walk a fine line every day in terms of the risks of violating one or more of the section 12 rights. Health professionals who make mistakes, do so in this context. Their profession by its nature takes them 'close to the bone' and therefore their responsibilities are and should be accordingly weighted. These rights, combined with that of human dignity, it is submitted are supportive of patient autonomy as opposed to medical paternalism. Security in and control over one's body implies that the person who lives in the relevant body has the power to decide what happens to it. Section 12 (2) specifically mentions the right not to be subjected to medical or scientific experiments without informed consent. This is not, it is submitted, a detraction from the general requirement of informed consent but rather the emphasis on medical research in which people have in the past been used as 'guinea pigs' without their full understanding or, in some cases, even

their knowledge. In a situation where the provider has a clear advantage over the patient in terms of expert skill and knowledge, more should be required of the possessor or professor of that expert skill and knowledge in terms of the distribution of risk between patient and provider. It is interesting that both cases involved the injection of lethal doses of medicine into the patients. This situation is one in which the patient is particularly vulnerable because ampoules of medicine used in injections are not usually first given to the patient in order that he may inspect the label, with one or two exceptions such as certain forms of diabetes, patients to not usually inject themselves, neither are they at liberty to eject or remove the medicine from their bodies once it has been administered. The emphasis of the court in *Mkwetshana*[75] on the need to take into account the route of administration is not without significance.

Clear evidence of the risks to the patient in medical paternalism is visible in the next case. Although it too predates the Constitution, it nonetheless recognises the right to bodily and psychological integrity at common law and to the extent that the common law concept of the right overlaps with the constitutional law concept, this case is a reflection of the position at constitutional law as well.

8.2.6 Buls v Tsatsarolakis[76]

Facts

The facts appear from the judgment of Nicholas J as follows: The plaintiff was a bricklayer. On 7 April 1972 he tried to start the engine of a concrete mixer. The engine backfired and the starting handle struck the plaintiff on his right wrist. He experienced severe pain and went to the Krugersdorp Hospital. There he saw Dr. Buls who attempted to examine the hand, but this was so painful that the plaintiff jerked it away, and Dr. Buls had to abandon his attempt to examine it.

---

75 *Mkwetshana* fn 72 *supra*

76 *Buls* 1976(2) SA 891 (T)

He then injected the hand and suspecting a fracture of the right wrist referred the plaintiff to the radiological department for X-rays. Two X-ray views were taken, but Dr. Buls found no evidence of a fracture. The plaintiff's hand was strapped with an elastoplast bandage by the sister in the casualty department. He was given tablets to reduce the swelling and other tablets to relieve the pain, and Dr. Buls told him to return after a week, by which time the part-time radiologist employed by the hospital would have reported on the X-rays.The plaintiff returned to the hospital on 14 April. He was still suffering from pain but it was not as severe. The swelling had almost gone. The radiologist had reported that no fracture was seen on the X-rays, and Dr. Buls communicated this to the plaintiff. He gave him ointment with which to massage the hand, and more tablets for the pain. According to the plaintiff, Dr. Buls told him that he was not to worry and that it was not necessary for him to come back. Dr. Buls, however, said in his evidence that he told the plaintiff that he should come back if he continued to experience pain. The magistrate found that while the plaintiff gave untruthful evidence in certain respects there was no reason to disbelieve Dr. Buls, whose evidence on this point he accepted. This finding was not challenged on appeal. The plaintiff did not return to the hospital. As he continued to experience pain, he consulted Mr. Bryer, a specialist orthopaedic surgeon, on 29 April. Mr. Bryer carried out a clinical examination which led him to suspect a fracture of the scaphoid bone of the right wrist. He referred the plaintiff for X-rays, and these revealed that there was such a fracture. Mr. Bryer then immobilised the plaintiff's wrist in plaster, which remained in position for a period. The plaintiff subsequently instituted the present action against the defendants, alleging that, as a result of Dr. Buls' negligence and lack of skill, the proper treatment of his wrist was delayed for three weeks until 29 April. He claimed damages made up as follows:

Pain and suffering for three weeks.....	R150.00
Loss of earnings for three weeks.....	R525.00
Fee - orthopaedic surgeon.....	R 80.00

Fee - radiologist - three examinations @ R8, 10 each .....R 24.30

R779.30

Dr. Buls was alleged to have been negligent as follows in the plaintiff's particulars of claim:

"The first defendant treated plaintiff for the said ailment negligently and unskilfully in that he:

(a) caused two X-ray pictures only of plaintiff's right wrist be taken by a radiologist in the employ of the Krugersdorp Hospital;

(b) failed to examine plaintiff's right wrist properly and failed to find that the scaphoid bone of this wrist was broken;

(c) failed to put plaintiff's wrist in plaster and thus to immobilise it, which is the correct and accepted medical practice;

(d) failed to cause further X-ray pictures to be taken when plaintiff consulted him again on 14 April and complained that he was still suffering much pain;

(e) failed again to immobilise plaintiff's wrist but advised him to massage it with an ointment;

(f) advised plaintiff wrongly on 14 April that a further consultation and examination of his wrist was not necessary;

(g) undertook the examination of plaintiff's right wrist and his treatment without possessing the required knowledge and skill."

Judgment

Nicholas J noted that during the hearing of the appeal a question arose whether the plaintiff's summons disclosed a cause of action. He observed that the cases of medical negligence in the South African law reports had all arisen out of physical injury or harm sustained by the plaintiff and that the present plaintiff alleged, not that he suffered personal injury or harm as a result of the negligence of Dr. Buls, but that he suffered pecuniary loss as a result of the delay in the treatment of the injury which he had sustained. Nicholas J stated that generally

speaking every man has a right that others shall not injure him in his person and that involves a duty to exercise proper care. He said that every man has a legal right not to be harmed and then asked whether, apart from a contract, there is a legal right to be healed? Observing that it is the professional duty of a medical practitioner to treat his patient with due care and skill, Nicholas J questioned whether, merely by undertaking a case, a medical practitioner becomes subject to a legal duty, a breach of which founds an action for damages, to take due and proper steps to heal the patient? He noted that this is an interesting question but, because it was not argued and because it is not necessary for the purposes of the present decision to answer it, he did not discuss it further.

The court observed that the standard of care required of a medical practitioner who undertakes the treatment of a patient is not the highest possible degree of professional skill, but reasonable skill and care[77]. It stated that in deciding what is reasonable, the evidence of qualified physicians is of the greatest assistance but that the decision of what is reasonable under the circumstances is, however, for the Court. It will pay high regard to the views of the profession, but it is not bound to adopt them The question in Buls' case was thus not how a specialist orthopaedic surgeon would have acted in the treatment of the plaintiff, but how an average general practitioner, carrying on his duties as a casualty officer in a public hospital, would have acted. Two orthopaedic surgeons gave expert evidence at the trial: one, Mr. Bryer, was called by the plaintiff; the other, Mr. Du Toit, by the defendant. Mr. Bryer's evidence was that Dr. Buls' conduct on 7 April was not subject to criticism. The clinical signs at that stage, so far as they were observable by Dr. Buls in the circumstances, did not clearly point to a

---

77 The court referred to *Mitchell v. Dixon*, 1914 AD 519 at p. 525 and also *R. v. Van der Merwe* (W.L.D. unreported) in which Roper J., said in a passage which was approved in *Esterhuizen v Administrator, Transvaal*, fn 17 *supra* at p. 723H, that the test to be applied is 'not what a specialist would or would not do under the circumstances... because a general practitioner is not expected to have the same degree of knowledge and skill and experience as a specialist has...The question is what is the common knowledge in the branch of the profession to which the accused belongs'. The court also referred to the dictum in *Van Wyk v. Lewis*, (fn 22 *supra*) of Wessels, J.A, at pp. 461 - 2: 'We cannot determine in the abstract whether a surgeon has or has not exhibited reasonable skill and care. We must place ourselves as nearly as possible in the exact position in which the surgeon found himself when he conducted the particular operation and we must then determine from all the circumstances whether he acted with reasonable care or negligently. Did he act as an average surgeon placed in similar circumstances would have acted, or did he manifestly fall short of the skill, care and judgment of the average surgeon in similar circumstances? If he falls short he is negligent.'

fracture of the scaphoid, the diagnosis of which is often missed. There would be similar symptoms where there was a soft-tissue injury of the area, and a number of other bones in the wrist could have been injured and which would have given rise to the same symptoms. Suspecting a fracture of one of the bones, Dr. Buls referred the case to the radiological section where the procedure and the views to be taken would be determined by the person in charge. In this case the radiological section did 'the usual thing in these hospitals' and took 'two standard views of the wrist'. Those views did not reveal a fracture, although Mr. Bryer said that to him, as an orthopaedic surgeon, there were suspicious features which would have persuaded him to call for additional X-ray views. Mr. Bryer said that he felt that the general practitioner was perfectly justified in the first instance in doing nothing more than he did but that when the plaintiff came back again a week later still complaining of pain, something more should have been done. So far therefore, the plaintiff had failed to establish a case. In regard to the second visit on 14 April it was Mr. Bryer's opinion that the plaintiff should then have been re-examined because, at that stage the possibility of a fracture of the scaphoid or of one or other of the bones in the wrist, should have been realised. But, he said, even if it was reasonably certain on clinical examination that the patient had a fracture it is essential that one takes X-rays to confirm the diagnosis. He agreed that it is possible to miss a fracture of the scaphoid even if a number of X-rays are taken. It was the view of Mr. Du Toit that the average time at which a crack-fracture of this bone tends to show up on an X-ray is three weeks after the original fracture. Mr. Bryer considered that the period was ten to fourteen days, but conceded that it could be three weeks. He agreed that some orthopaedic surgeons would request further X-rays in a case where the original X-rays had not revealed the fracture in two weeks, and others in three weeks and that an orthopaedic surgeon was not to be criticised who allowed three weeks to elapse. He did not therefore criticise Dr. Buls for failing to diagnose the fracture of the scaphoid bone on 14 April. He did say, however, that a clinical examination would have revealed this as a strong probability and that, if the doctor feels certain there is a fracture, he should immobilise the wrist

and have further films taken in about 14 days. He agreed that from the plain point of view of diagnosis, there is no criticism if he has missed the fracture the first time, to come back in 14 days for the second X-ray but he should do something to relieve the pain, namely, by immobilising the wrist in a plaster cast.

In the view of Mr. Bryer, therefore, Dr. Buls was not negligent in the respect alleged in para (d) of para. 6, but was negligent in the respect alleged in paragraph (e). In this regard, Mr. Du Toit disagreed. He considered that there was no neglect of duty by Dr. Buls on 14 April. His conduct was that which he would have expected from an ordinary casualty officer. Dr. Buls was not an expert in problems of the type which arose, and he gave to it the attention of a general practitioner. The fracture of the scaphoid bone is a very difficult one to diagnose. At the interview on 14 April Dr. Buls was reassured clinically by the fact that the swelling had gone, if not completely, then at any rate substantially, and that the pain was reduced. He had been informed by the hospital's radiologist that there was no fracture visible on the X-rays, and the average doctor would have accepted that opinion. He told the plaintiff that if the wrist continued to trouble him, he should come back. n the light of this evidence, and having regard to the onus, it is impossible, said Nicholas J to hold that the plaintiff established the negligence referred to in paragraph (e). So far as paragraph (g) was concerned, he held that there was nothing in the evidence to suggest that Dr. Buls lacked the requisite knowledge and skill to undertake the examination and treatment of the plaintiff in the initial stages, and after 14 April 1972, the plaintiff did not return to the hospital. The plaintiff failed, therefore, to establish any of the particulars of negligence alleged by him. The appeal was upheld with costs.

Discussion

In relation to the question of the legal right to be healed raised by Nicholas J in this case, Strauss[78] submits that the answer is as follows: where a patient consults a doctor who undertakes to treat him, the doctor assumes no greater duty than to treat the patient with due care and skill, unless the doctor has expressly guaranteed that the patient will be healed by his treatment – something which the prudent doctor will not generally do. He notes that this is also the view of the English courts and refers to the case of *Greaves & Co (Contractors) Ltd v Baynham Mickle and Partners*[79] in which Lord Denning states concerning the 'employment of a professional man' that "The law does not usually imply a warranty that he will achieve the desired result, but only a term that he will use reasonable care and skill. The surgeon does not warrant that he will cure the patient. Nor does the solicitor warrant that he will win the case". However, Strauss points out in another chapter[80] that a wrong diagnosis may result in a doctor be held liable for damages if the diagnosis is causally responsible for wrong treatment being given to a patient or the patient suffering injury in another manner. It is respectfully submitted that the correct answer to the question in a contractual setting as to whether or not the patient has a right to be healed or cured is dependent upon the terms of the contract, whether express or implied, in each situation. A contract for cosmetic surgery for instance, in which the surgery is carried out for the express purpose of reducing the size of the patient's breasts by stated measurements gives a right to very specific performance indeed as does a contract for the carrying out of a hysterectomy in order to remove a diseased uterus. Similarly contracts for the removal of an inflamed appendix, for the supply of eyeglasses to correct a visual defect, for a test for a particular genetic defect in a foetus, or for the termination of a pregnancy, or the insertion of an artificial hip are all quite specific in terms of the expected outcome. Failure to do what is minimally

78 Strauss fn 17 *supra* p 40-41
79 *Greaves* [1975] 3 All ER 99 (CA)
80 Strauss fn 17 *supra* at p 252

necessary to achieve the anticipated or expected outcome is likely to give rise to legitimate claims for breach of contract.

The question is whether, in the delictual context, the constitutional right of access to health care services including reproductive health care introduces any new, or strengthens any existing, obligation on the part of a provider of health care services to ensure that the envisaged service is properly, correctly or adequately rendered. In the case of a disabled patient who is admitted to hospital for the treatment of pressure sores, for instance, could the failure of the nursing staff to turn the patient regularly so as to ensure his recovery from pressure sores and to prevent the development of new ones be seen as a violation of that patient's constitutional right of access to health care services? If constitutional rights are to be enforced not through the creation of new legal actions but using the existing actions available at common law, then in order to succeed in an allegation that this constituted a violation of his constitutional rights, the patient would have to satisfy all of the requirements of the law of delict with regard to proof of negligence etc. The patient could also, technically speaking, while he is still an inpatient apply to court for an urgent order compelling the hospital to give him proper nursing care on the basis that their neglect of him is violating his constitutional right of access to health care services but this is unlikely to happen in practice. It is submitted firstly that the in the delictual context, the constitutional right of access to health care services, strengthens rather than adds to, the obligations of a health provider to give proper care and treatment to a patient since the right impacts on the question of the wrongfulness or unlawfulness of the provider in not doing so. It is submitted secondly that the constitution also strengthens the idea that even in the absence of a contract there is a legally recognised relationship between a provider and a patient under his care although this has already been recognised in cases such as that of *Dube v Administrator Transvaal*[81] discussed previously. It is submitted thirdly that the word 'access' must be interpreted broadly to be meaningful and

---

81 *Dube* fn 64 *supra*

effective access, i.e. access to services that are likely to effect a cure, alleviate symptoms or otherwise improve the patient's health status or condition since a narrower interpretation would amount effectively to a denial of the right. To put it differently, access to treatment that does not meet standards of general efficacy, safety and quality is not access for constitutional purposes. It is submitted fourthly that the constitution could in certain circumstances create an obligation on the part of a provider to treat a person in a situation in which the law previously did not recognise such an obligation since the existence of a right of access to health care services, it could be argued, shifts the onus from the person seeking the services to show reasons why a particular provider should have treated him or her, to the provider refusing those services to show reasons why the access was denied. It is submitted fifthly that, due to the fourth submission above, the possibility of a claim in delict involving denial of access, in both obvious and subtle ways, to health care services is greatly enhanced by the existence in constitutional law of a right of access to health care services since previously no such right existed and the question of an obligation to treat a person was thus unlikely to rise except in the narrowest of circumstances[82].

Claassen and Verschoor[83] point out that in *Buls*, the patient for the first time in South African legal history based his action on pure economic loss suffered by him as a result of the alleged negligence of the defendant-practitioner. They note that in previous cases such claims were usually based on the personal injuries or prejudice suffered by the plaintiff. They point out that only two actionable wrongs are known in South African law, namely *damnum injuria datum* (damage wrongfully caused) and *injuria* (injury to personal dignity) and

---

82 Strauss fn 17 *supra*, writing pre-constitutionally, notes at p3 that as a general rule the independently practising doctor is under no obligation to treat any person requesting his services. As a so-called independent contractor he is at liberty to select or refuse patients at will. He notes, however, that this is qualified in two respects only: First, a doctor who arbitrarily and unreasonably refuses to attend to a seriously ill or injured person may be held liable if the patient cannot manage to get another doctor and suffers harm. Secondly, once a doctor has accepted a patient and has embarked upon a specific course of treatment, he may not unilaterally abandon the patient if abandonment might be harmful to the patient. It is submitted that although Strauss refers only to 'the doctor', these rules were applicable to other health professionals and providers of health care services such as public and private hospitals as well. The term 'provider' is used in this thesis to indicate all such providers of health care services including 'doctors'.

83 *Claassen and Verschoor* fn 5 *supra*

that the commission of every delict constitutes, between the perpetrator and the injured person, an obligation implying a legal claim in favour of the injured party and aimed at the obliteration of the injury. They further note that in South African law there are mainly three actions which are ex delicto aimed at the recovery of damages, to wit, the *actio legis Aquiliae* for the recovery of damages, the *actio injuriarum* for the redress of moral damages where a personality right has been injured intentionally and the action for pain and suffering flowing from negligent impairment of (sic) physical injury. They point out that Neethling *et al*[84] refer to these actions as the three pillars of the South African law of delict.

8.2.7 Magware v Minister Of Health NO [85]

Facts

As the result of an accident on 3 April 1978 plaintiff sustained an unstable bimalleolar fracture dislocation of his right ankle. Plaintiff attended at the casualty department of Harari Hospital on diverse occasions during the period between 3 April 1978 and 27 June 1978 and upon each such occasion he paid the prescribed fee and was treated by the casualty medical staff for his said injury. The aforesaid casualty medical staff were at all times relevant to these proceedings acting in the course and within the scope of their employment with the Ministry of Health, of which Ministry the defendant is the responsible Minister. In the premises, the parties concluded an implied agreement in terms of which defendant undertook through his duly appointed employees to treat plaintiff on each such occasion for his said injury. It was a material term of the said implied agreement that defendant's employees would conscientiously employ reasonable care and skill in their treatment of plaintiff. In breach of the said term of the parties' agreement defendant's employees failed to apply due

---

84 Neethling, Potgieter and Visser 1989 *Deliktereg*

85 *Magware* 1981 (4) SA 472 (Z)

care and skill in their treatment of plaintiff's injury in one or more of the following respects:

(a) they applied a plaster of Paris cast to plaintiff's ankle without ensuring that it was moulded appropriately to stabilise and prevent slippage of the said fracture dislocation to the ankle;

(b) after they had applied the said plaster of Paris cast they failed to check the said fracture dislocation by means of X-rays on 3 or 4 April 1978 as they should have done, and only made such a check on 17 April 1978;

(c) despite the fact that the X-ray taken on 17 April 1978 revealed that the fracture was in an unacceptable position and required immediate correction, they failed to take the appropriate action necessary to correct it.

Alternatively he alleged that the defendant's employees, in breach of their duty to employ reasonable care and skill in their treatment of plaintiff, were negligent in their treatment of him.

In his plea the defendant denied any contractual relationship between the parties. However, paras 4 and 5 of his plea read as follows:

4. Defendant admits the negligence alleged in para 7, as particularised in para 6, but avers that such negligence consisted only of acts of omission, not giving rise to delictual liability on the part of defendant

5. Save that it is admitted that plaintiff's injury did not heal as it would have done with the correct treatment, and save that defendant has no knowledge of the quantum of damage alleged, does not admit it and puts plaintiff to the proof thereof, defendant denies the allegations in para 8.

The plaintiff excepted to para 4 of the plea on the basis that the negligence which defendant admitted, as particularised in para 6 of plaintiff's declaration, was such as can give rise in law to delictual liability on the part of defendant towards plaintiff and in the premises, the defendant's defence to the alternative basis upon which plaintiff's claim was founded, namely that his servants' admitted negligence did not give rise to liability in delict, was bad in law. In the

judgment the plaintiff is referred to as the excipient and the respondent as the defendant.

Judgment

Counsel for the defendant, submitted that the negligence alleged by the plaintiff consisted only of acts of omission and that where there were acts of mere omission there was no liability[86]. Counsel argued that the instant case was one of ineffective treatment and that liability in medical matters depends on a prior act of commission which is something more than the mere acceptance of the patient or the application of ineffective treatment.

Counsel for the excipient referred to two English cases. In England the position appeared to be that doctors and hospital authorities, whenever they accept a patient for treatment, are under a duty to use reasonable care and skill to cure him of his ailment[87]. Reference was also made by counsel for the excipient to *Barnett v Chelsea & Kensington Hospital Management Committee*[88] in which the deceased had, with two other watchmen, reported to the hospital. They told the nurse in the casualty department that they had been vomiting continuously after drinking tea and wished to see a doctor. The nurse telephoned the doctor and informed him of this. He instructed the nurse to tell the watchmen to see their own doctors. Later the deceased died of arsenical poisoning. It was held that, in failing to see and examine the deceased and in failing to admit him to hospital and treat him, the hospital's casualty officer was negligent and did not discharge the duty of care which in the circumstances was owed to the deceased by the defendant as hospital authority. Smith J noted that *Donoghue v Stevenson* and *Le Lievre v Gold* were referred to in relation to close and direct relations between persons giving rise to a duty to take care, and that Nield J

---

86 Reliance was placed on *Halliwell v Johannesburg Municipal Council* 1912 AD 659, *Van Wyk v Lewis* (fn 24 *supra*); *Blore v Standard General Insurance Co Ltd en 'n Ander* 1972 (2) SA 89 (O).

87 *Cassidy v Ministry of Health* (1951) 1 All ER 574 at p 585 per Denning LJ.

88 *Barnett* (1968) 1 All ER 1068

stated that in his judgment there was here such a close and direct relationship between the hospital and the watchmen that there was imposed on the hospital a duty of care which they owed to the watchmen.

Smith J in *Magware* observed with regard to South African law that it had been decided by the Appellate Division in South Africa that prior conduct or the control of property are not essential to the creation of a duty to act for the safety of others, although they may be factors in the totality of circumstances from which such a duty is inferred[89]. He noted that Steyn JA in a minority judgment in *Silva's Fishing Corporation (Pty) Ltd v Maweza*[90] said:

"The Roman law, as also the Roman-Dutch law, recognises the principle that, generally speaking, no one is bound to mind the business of another, even where he can, with no danger or expense to himself, avert serious harm from the other, and that no liability is incurred by refraining from doing so, even if the omission should violate a moral duty. Indeed, Cujacius *Opera Omnia* 8 C329, points out that in general it is culpable to meddle with the affairs of another which do not affect you and are none of your business. But there is a variety of circumstances, some of them unconnected with prior conduct, which impose the duty to act in order to avoid reasonably foreseeable loss to another. The circumstances which will give rise to such a duty may differ according to the conceptions prevailing in a particular community at a given time."

Smith J observed that MacDonald ACJ cited with approval the last sentence of this statement in *King v Dykes*[91] and went on to stated that so far as he was concerned the law to be applied was stated by MacDonald in *King v Dykes*[92]. Smith J stated that in deciding whether a legal duty of care exists, one must

---

89 *Minister van Polisie v Ewels* 1975 (3) SA 590 (A). In this case it was held that members of the police force had been under a duty to stop another policeman from assaulting a man in a police station. See, particularly, at 596 - 597 (English translation). At 597 Rumpff CJ, having stated that prior conduct or the control of property are not essential requirements for unlawfulness, goes on to say:
"It appears a stage has been reached where an omission is regarded as unlawful conduct when the circumstances of the case are such that the omission not only occasions moral indignation but where the legal convictions of the community require that the omission be regarded as unlawful and that the loss suffered be compensated by the person who failed to act positively. When determining unlawfulness, one is not concerned, in any given case of an omission, with the customary 'negligence' of the bonus paterfamilias, but with the question whether, all facts considered, there was a legal duty to act reasonably." See, also, 1975 South African Law Journal at 361 and 1975 Annual Survey of South African Law at 170.

90 *Silva's Fishing Corp* 1957 (2) SA 256 (A) at p265

91 *King* 1971 (3) SA 540 (RA)

92 MacDonald ACJ in *King v Dykes* (fn 91 *supra*) at p543 criticised any attempt to categorize events preceding an omission as "prior conduct", among others. He said that the Court must apply the universal and basic test of deciding whether or not a legal duty exists in the particular circumstances of the case.

have regard to all the facts of the case and the conceptions prevailing in the particular community at a given time.[93]

Counsel for the excipient submitted that the present case was similar to *Dube v Administrator, Transvaal*[94] and *Blyth v Van den Heever*[95]. Both of these cases related to the treatment of a fractured arm. Smith J noted that in *Dube* Trollip J said that the plaintiff's action was founded on delict and not on contract. Because the hospital accepted the plaintiff as a patient, its staff owed him a duty to attend to and treat him with due and proper care and skill. *Blyth* was based on negligent omissions. Counsel for the defendant submitted that in each of these cases there was a prior act of commission. Smith J said he thought that this latter submission is correct, but that it was noteworthy that in neither case was there any mention of a prior act of commission as such.

Smith J observed that on the instant case the plaintiff attended at the casualty department of Harari Hospital on diverse occasions and was treated by the casualty medical staff for his injury. They applied a plaster of Paris cast to his ankle. They were negligent in the way they applied the plaster of Paris cast and were thereafter guilty of negligent omissions. This means that they ought as reasonable men to have foreseen that their inaction might entail harm for the plaintiff and that they had the means to avert such harm and that they failed by reasonable action to prevent it. He said that it was clear that there was a moral and professional duty to act reasonably towards the plaintiff and that, on the facts, once the defendant's employees had undertaken treatment and had engaged in applying the plaster of Paris cast, there was set up a special relationship between defendant's employees, the casualty medical staff, and the

---

93 At p 545 of *King v Dykes* (fn 91 *supra)* MacDonald ACJ said that in general it is the legal duty of an occupier of land to take steps to prevent a hazard on his land causing harm to persons who, by reason of their proximity, may be harmed if the hazard is not dealt with. He went on to say whether in a particular case such a legal duty exists is to be decided in the main by factors such as those mentioned in *Goldman v Hargrave* (1967) 1 AC 645: "... a balanced consideration of what could be expected of the particular occupier as compared with the consequences of inaction."

94 *Dube* fn 64 *supra*

95 *Blyth* 1980 (1) SA 191 (A)

plaintiff, different from the relationship between the plaintiff and a disinterested stranger. The plaintiff was in the care of the defendant's medical staff. Smith J held, on a consideration of the facts and what could be expected of the casualty medical staff as compared with the consequences of inaction, and having regard to the conceptions prevailing in the country, there was a legal duty to act reasonably. The exception was upheld with costs. The defendant was given leave to amend his plea within 12 days from the date of judgment.

Discussion

This case is another one in which the court found that there was an obligation between the provider and the patient on the basis of the law of delict and that a contractual relationship was not a *sine qua non* of that relationship. This case and the South African cases cited by the court in its judgment contain persuasive justification for the broad interpretation of the term 'access' suggested by the writer in the discussion under *Buls v Tsatsarolakis*[96]. Health care services rendered to patients must be of a standard of quality, efficacy and safety that can reasonably be expected of persons who are qualified and duly licensed to render the services in question. There is a duty on providers of health care services to act reasonably in the rendering of those services. In this case the actions of the defendants amounted to negligent omissions. Strauss refers to the US case of *Hurley v Eddingfield*[97] in discussing the right of a doctor to refuse to treat a patient. In this case the Indiana Supreme Court held expressly that 'the state does not require and the doctor does not engage that he will practice at all or on other terms than he may choose to accept.' In this case, reports Strauss, a doctor refused to attend an ailing man, although there were no other patients demanding his services at the time. He failed to give any reasons for his refusal. Strauss notes that the right of a doctor to arbitrarily refuse to

---

96 *Buls* fn 76 *supra*

97 *Hurley* 156 Ind 416, 59 NE 1058 (1901)

accept any person as a patient - even in a dire emergency - has subsequently been reaffirmed by numerous American authorities. These authorities, he says, also emphasise that the mere fact that a doctor on previous occasions rendered a patient services does not affect the right of the doctor to subsequently refuse to attend that patient. In South African law, says Strauss, the doctor's right of refusal was traditionally justified on the ground that no one could be held liable for a so-called "mere omission". Strauss points out that according to the customary view, liability for an omission could only be incurred in special circumstances such as the following:

- Where the defendant has by a 'positive' act created a potentially dangerous situation and refrains from taking steps to avoid the danger. In the medical situation an example would be where a doctor spontaneously commences treatment of the victim of a traffic accident and then, when the patient is still in need of continued treatment, 'abandons' him;
- Where the defendant has assumed control over a dangerous object and then neglect to exercise proper care over it. A possible medical example would perhaps be where Dr A has commenced a blood transfusion; his attendance elsewhere is required urgently and he requests his colleague, Dr B, to carry on with the transfusion; B fails to exercise proper care over the apparatus or the procedure.
- Where the defendant is under a statutory duty to act and neglects to do so e.g. a district surgeon or medical officer of health fails to vaccinate patients who present for compulsory vaccination.
- Where the defendant has by contract assumed certain duties and fails to carry these out, e.g. a casualty officer in the employ of a hospital authority fails to attend an injured patient brought into his ward.

Strauss notes that in all these cases the plaintiff would have to prove that the doctor's omission was either intention or accompanied by negligence.

It is submitted with regard to the situation in *Hurley* that in South Africa it is highly unlikely, in view of the constitutional right of access to health care

services, that a provider would be able to get away with behaving in such a manner. A provider approached for treatment by a person would have to have substantial reasons for not doing so in order to swing the balance in his favour. Furthermore the rigid distinction in South African law previously between wrongful acts and omissions has become increasingly blurred since *Minister van Polisie v Ewels*[98] and, it is submitted, that in view of the test for wrongfulness currently used by the courts based as it is on the legal convictions of the community or the *boni mores*, there is no sound reason for artificially maintaining such a distinction or seeking to find prior conduct on the part of the defendant such as the examples given by Strauss above indicate. To suggest otherwise would be to suggest different tests for wrongfulness depending on whether it was an act or omission that caused the harm. This is not only logically unnecessary but, it is submitted, legally incorrect if the test of wrongfulness is based on public policy informed by the values and principles of the Constitution since the latter do not vary in their substance depending on whether there was an act or an omission. In fact in constitutional terms, the denial of a right, eg the right of access to health care services, can be seen as an omission to act in the required manner as much if not more than as a positive action (a refusal) to act in the required manner.

8.2.8 *S v Kramer*[99]

Facts

On the morning of 4 December 1981 the deceased, a 10 year old girl was admitted to the Rydal Clinic in Boksburg where she was to undergo a tonsillectomy and adenoidectomy. She was a healthy, happy child with no other physical problems. The deceased was treated by accused No 1 who *inter alia* gave her tablets in preparation for the operation. On arriving at the clinic the

---

98 *Ewels* fn 89 *supra*

99 *Kramer* 1987 (1) SA (N)

deceased was weighed, prepared for the operation and taken to the theatre. In the theatre, accused No 1 was to perform the duties of a surgeon and accused No 2 the duties of an anaesthetist. Accused No 2 examined the deceased in the theatre. Thereafter he administered atropine, prabanthol and scolene. Pure oxygen was thereafter administered through a face mask for a few minutes. Accused No 2 then chose an endotracheal tube which he inserted through the nose into the trachea with the aid of a laryngoscope and McGil forceps. Sister Lansdown then connected the tube to the Boyles machine and secured the connections. The deceased was ventilated manually for some time. Accused No 1 then asked accused No 2 for permission to proceed with the operation, which permission was given. A mouth gag was put in and accused No 1 started curretting the adenoids. That having been completed, accused No 1 started to remove the left tonsil. As he was doing that he noticed an excess of bleeding. The blood was dark in colour and the deceased was also showing signs of waking up. It was then also obvious that the deceased was cyanosed. Accused No 1 removed the left tonsil, sucked the blood in the throat away and, with the aid of a laryngoscope, came to the conclusion that the tube was not in the trachea. He immediately ordered further doses of phabanthol and scolene to be administered, removed the tube and re-intubated the deceased with another tube. The deceased was ventilated. Her colour improved. She suddenly became cyanosed again and as no pulse was palpable, cardiac massage was started. Attempts were made to stimulate the deceased's heart with a defibrillator but to no avail. The deceased died in theatre. In convicting accused No 1 of culpable homicide the court a quo found that he was negligent in the following respects:

(a) Accused No 1 should have ensured that the endotracheal tube had been correctly inserted by accused No 2. The court *a quo* found that this duty on accused No 1 Arose as a result of the following:

(1) Accused No 1 knew that accused No 2 was a relatively inexperienced anaesthetist.

(2) Accused No 1 knew that each and every anaesthetist can place an endotracheal tube wrongly.

(3) Accused No 1 admitted at the inquest that had he checked if the tube had been correctly placed the deceased's death could have been avoided.

(b) Accused No 1 should not have removed the left tonsil after he had seen the dark blood. In doing so he delayed commencing the resuscitative measures.

(c) Accused No 1 should not have ordered accused No 2 to inject more scolene, a drug that would paralyse the lungs of the patient and prevent her from breathing normally.

Accused No 1 appealed against his conviction on the following grounds:

1. The court erred in convicting accused No 1 of culpable homicide.
2. The court should have found that the state failed to prove beyond reasonable doubt that:
   (a) accused No 1 was negligent, either as alleged in the further particulars to the charge sheet or at all;
   (b) accused No 1's negligence, if any, was causally connected to the death of the deceased.

3.1 The court erred in finding that accused No 1 delayed in taking steps to ensure that the intratracheal tube was correctly placed and/or to take resuscitative measures.

3.2 The court should have found that once accused No 1 saw that the deceased was bleeding excessively in the throat and that the blood was dark in colour, he:
   (a) acted immediately in order to ascertain precisely what the cause was of these two phenomena; and/or
   (b) immediately took steps to establish an airway.

3.3 The court should have found that, on Professor Cooper's evidence, the state failed to prove that accused No 1 had not acted properly in the emergency situation in which he, as surgeon, found himself.

4.1 The trial court erred in finding that accused No 1 should not have told accused No 2 to use Scoline on the second occasion.

4.2 The trial court should have found that it was essential for an intratracheal tube to be reintroduced and that in order to do so a muscle relaxant, such as Scoline, had to be used.

5.1 The trial court erred in finding that, before commencing the operation, accused No 1 should have checked to see that the intratracheal tube had been correctly placed by accused No 2.

5.2 This finding was in direct conflict with the evidence of Professor Cooper, whose evidence it was that it was not the surgeon's function to ensure that the intratracheal tube had been correctly placed by the anaesthetist.

5.3 The trial court furthermore erred in finding that accused No 1 should have foreseen that accused No 2 might insert the intratracheal tube incorrectly.

5.4 The trial court should have found that accused No 1, as surgeon, was entitled to assume that accused No 2, who was qualified to act as anaesthetist, would insert the intratracheal tube correctly.

In convicting accused No 2 of culpable homicide the court *a quo* found that he was negligent in the following respects:

(a) he should not have relied on Sister Lansdown to choose an appropriate length of endotracheal tube as it was possible that the tube which was inserted was too short or that it was not inserted deep enough into the trachea;

(b) he did not insert the tube into the trachea at all;

(c) he did not monitor the patient's condition adequately and therefore did not timeously detect that the supply of oxygen to the patient's lungs was inadequate. In coming to this conclusion the court a quo found that accused No 2 should have made use of a blood pressure cuff and an ECG machine;

(d) he should not have frozen at the first signs of a crisis as he was busy with a dangerous undertaking and the patient's life was in his hands.

Accused No 2 appealed against his conviction and sentence. The grounds on which the appeal was based were as follows:

1. The learned magistrate erred in finding that appellant was negligent; alternatively that his negligence caused the death.

2. Regarding the finding that appellant was negligent in relying on an experienced nurse to check the anaesthetic drugs for him, there was no evidence that this conduct constituted negligence or that any mistake was made connected with the drugs or that any such mistake caused the death.

3. Regarding the finding that he was negligent in relying on an experienced nurse to choose an appropriate length of endotracheal tube, there was no evidence that this conduct constituted negligence or that any mistake was made connected with the length of the tube or that any such mistake caused the death.

4. Regarding the finding that he was negligent in failing to check that the endotracheal tube was inserted deeply enough into the trachea, there was no evidence of any such failure or that any such failure caused the death.

5. Regarding the finding that he was negligent in failing to insert the endotracheal tube into the trachea at all:
   5.1 the learned magistrate erred in that he relied entirely on appellant's admission at the inquest that it was possible that he had inserted the tube incorrectly;
   5.2 there was evidence that the time from oxygenation to the time when the blood went dark, i.e. over 6 minutes, indicated that the tube had been inserted correctly.

6. Regarding the finding that he was negligent in not putting a blood pressure cuff on the child, there was no evidence that this constituted negligence or that the child's life would beyond a reasonable doubt have been saved had the blood pressure cuff been put on.

7. Regarding the finding that he was negligent in not using an ECG, there was no evidence that this constituted negligence or that the child's life would beyond a reasonable doubt have been saved had he used one.

8. The learned magistrate should therefore have held that it had not been proved beyond a reasonable doubt that appellant was negligent in any manner which caused the death and should have acquitted him.

Judgment

Van der Merwe J referred to the authorities, stating that before dealing further with the facts of this appeal, the findings of the court *a quo* and the grounds of appeal it was necessary to refer briefly to the test to be applied in concluding that a medical practitioner was negligent in the performance of his duties.[100] He

---

100 He noted that: In *Mitchell v Dixon* 1914 AD 519 at 525 it was stated that 'A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not.'
In *Van Wyk v Lewis* (fn 24 *supra*) at p 444 Innes CJ again dealt with the degree of skill and care expected from a medical practitioner where he explained the principle laid down in the Mitchell case supra as follows: 'It was pointed out by this Court, in *Mitchell v Dixon* 1914 AD at 525, that "a medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care." And in deciding what is reasonable the Court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs. The evidence of qualified surgeons or physicians is of the greatest assistance in estimating that general level. And their evidence may well be influenced by local experience; but I desire to guard myself from assenting to the principle approved in some American decisions that the standard of skill which should be exacted is that which prevails in a particular locality where the practitioner happens to reside. The ordinary medical practitioner should, as it seems to me, exercise the same degree of skill and care, whether he carries on his work in the town or the country, in one place or another. The fact that several incompetent or careless practitioners happen to settle at the same place cannot affect the standard of diligence and skill which local patients have a right to expect.'
In *Webb v Isaac* 1915 EDL 273 at 276 where Graham JP was reported to have said:' The law upon the duties of a medical practitioner and the amount of skill which is expected of him has been discussed in the case of *Mitchell v Dixon* which was decided by the Appellate Court quite recently. In that case, the Chief justice in giving judgment said that the plaintiff's case was based upon negligence, that is, upon the want of reasonable skill which the law requires under the circumstances, and he pointed out that a medical practitioner is not expected to bring to bear upon a case the highest possible degree of professional skill, but that, if he did not employ reasonable skill, he was liable for the consequences. The learned Chief justice went on to point out that the burden of proof that the injury, of which the plaintiff complained was caused by defendant's negligence,

observed that these principles are applicable to a medical practitioner in the performance of any task he has undertaken, whether it is general diagnosis and treatment or whether he is performing a task in the operating theatre. Problems that may arise as a result of an operation are complicated by the fact that in an operation a number of different people take part, each with his own important duties to perform in the course of the operation. The court stated that if a mishap should occur during the operation, it is of importance to ascertain who was responsible for the mishap and to what extent any other member of the operating team can be held liable for the actions of that person.

In the present case it was never suggested that any one of the two nurses was responsible for the mishap or that the accused were liable as a result of negligence on the part of any one of the nurses. The court was of the opinion

---

rested throughout upon the plaintiff: that the mere fact that the accident occurred was not in itself prima facie proof of negligence, and that the maxim *res ipsa loquitur* did not apply. There are excellent reasons for this rule of law, because it seems to me that, if the law required in every case that a practitioner should have the highest degree of skill, it would lead to this result - that in remote country districts, and even in country districts at no very great distance from the large centres, it would be impossible to find a country practitioner who would take the risk of attending a patient, if he was always expected to exercise the highest degree of skill obtainable in the medical profession. The law requires of a doctor a reasonable degree of skill, which is dependent upon the particular circumstances of the case which he has under treatment.'
See also *Coppen v Impey* 1916 CPD 309 at 314 where Kotze J was reported to have said: 'But taking it that the probability is that these ulcers and the consequent condition of the plaintiff's right-hand, are attributable to such a burn, I have next to consider whether this burn is due to negligence or unskillfulness on the part of Dr Impey or his assistant, as alleged in the declaration. Before doing so it will be advisable to state succinctly the law applicable to the responsibility of a medical man in the treatment of his patient. While, on the one hand, he does not undertake to perform a cure, or to treat his patient with the utmost skill and competence, he will, on the other hand, be liable for negligence or unskilfulness in his treatment; for, holding himself out as a professional man, he undertakes to perform the service required of him with reasonable skill and ability.' See further *Buls and Another v Tsatsarolakis* [fn 76 *supra*] at p 893 *in fine* - 894D. See also Boberg, *The Law of Delict* [fn 28 *supra*] at p 346: 'Obviously the ordinary reasonable man test of negligence cannot be applied to an activity calling for expertise that the ordinary man does not possess. One cannot judge a surgeon's conduct by asking how a diligens paterfamilias would have operated, for either he would not have operated at all (which is most likely) or, if he would have operated (in some rare emergency), he would no doubt have done worse than even the most barbarous surgeon. And so there emerges the reasonable expert - a practitioner like the actor, both possessing no especial flare or frailty; the reasonable doctor, the reasonable auditor, the reasonable mechanic. It is he who looks over the actor's shoulder to see if he attains the standard of his peers, for if he does not, he is negligent. That standard, it has been held, is not the highest level of competence: it is a degree of skill that is reasonable having regard to "the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs" (per Innes CJ in *Van Wyk v Lewis* fn 22 *supra* at 444). Thus it was held in *Buls v Tsatsarolakis* [fn 69 *supra*] that a general medical practitioner is not expected to display the knowledge and skill of a specialist orthopaedic surgeon.'
The court noted that the same principles are applied in English law. See, inter alia, *Mahong v Osborne* [1939] 1 All ER 535 at 548A - C: 'Before I discuss the Judge's summing up, it is desirable to recall the well-established legal measure of a professional man's duty. If he professes an art he must be reasonably skilled in it. There is no doubt that the defendant surgeon was that. He must also be careful, but the standard of care which the law requires is not insurance against accidental slips. It is such a degree of care as a normally skilful member of the profession may reasonably be expected to exercise in the actual circumstances of the case in question. It is not every slip or mistake which imports negligence, and, in applying the duty of care to the case of a surgeon, it is peculiarly necessary to have regard to the different kinds of circumstances that may present themselves for urgent attention.' See also *Medical Negligence* by Nathan [fn 65 *supra*] at p 22.

that, in general, neither the surgeon nor the anaesthetist was liable for the other's negligence. It held that this general rule would, however, be subject to exceptions, for example, where the surgeon knew that the anaesthetist was incompetent or not in a fit condition to perform his duties. Van der Merwe J said that there may also be other exceptions.[101] He referred to the *dicta* of Wessels JA in *Van Wyk v Lewis*[102] and said that the same principles hold true for the surgeon and the anaesthetist. They are not agents of one another. They are not employed and controlled by one another. Each one performs a specific specialised function as part of a team consisting of surgeon, anaesthetist and nursing staff. The court agreed with the submission on behalf of accused No 1 that there was no evidence produced that there was a duty on accused No 1 to check that accused No 2 had correctly placed the tube. It said that on the evidence there was nothing which occurred prior to the operation on the day in question which should have alerted accused No 1 to the danger that the deceased was not receiving an adequate supply of oxygen. There was no evidence to justify the court *a quo*'s finding that because of accused No 2's relative inexperience as an anaesthetist and the fact that any anaesthetist can make a mistake, accused No 1 should have checked that the tube had been correctly placed. Van der Merwe J was therefore of the opinion that there was no duty in law on accused No 1 to have looked down the trachea of the deceased to check the position of the tube before commencing the operation.

---

101 He referred to *Helgesen v SA Medical and Dental Council* 1962 (1) SA 800 (N), Meredith *Malpractice Liability of Doctors in Hospitals* at p 102 and SA Strauss & M J Strydom *Die Suid-Afrikaanse Geneeskundige Reg* , fn 16 *supra* at 281.

102 *Van Wyk* fn 24 *supra* at p 460: "In determining whether a surgeon conducting an abdominal operation in a hospital is entitled to place reliance on the counting of the swabs by a qualified and competent hospital sister and whether by so doing he has exercised a reasonable degree of skill, care and judgment, we must consider the prevailing practice of the profession and all the circumstances surrounding the operation. The Court can only refuse to admit such a universal practice if in its opinion it is so unreasonable and so dangerous that it would be contrary to public policy to admit it. In determining whether such a practice is reasonable or not, the Court must take into consideration the advance of medical science and modern practice. Thus in the present aseptic treatment of patients, it is difficult for the surgeon to do all the work alone: all possible germs must be destroyed which may be deleterious to the patient: the rooms, the instruments and all the other appliances must be rendered aseptic as far as possible. If the doctor were required to do all these things personally it would not be for the benefit of patients generally but to their detriment. Important and necessary work preliminary to an operation and upon which the success or failure of the operation may depend, must necessarily be left to the hospital sister and her nurses. We must therefore admit that in operations some team-work, as it has been called by several witnesses, is essential. The work has become specialised so as to enable the surgeon to devote all his energy and attention to the highly skilled and difficult work of isolation, dissection and purification. To what extent a doctor should or should not rely upon the team-work of the hospital assistants depends entirely on the nature of the particular case."

The concession made by accused No 1 at the inquest that had he looked down the trachea the death of the deceased could have been avoided, is to state the obvious. In making the concession accused No 1 did not say that it was his duty to check the position of the tube.

Van der Merwe J held that the court *a quo* was wrong in finding that accused No 1 was at fault to have ordered accused No 2 to inject more scolene, a drug that would relax muscles and therefore also paralyse the lungs of the patient. He said that accused No 1 was faced with two problems, namely, a patient who was obviously not receiving a sufficient supply of oxygen and who was 'too light' - that is, waking up. Accused No 1 had to establish an airway. He also had to prevent blood going into the lungs. He furthermore had to administer anaesthetic gasses which were at that stage supposed to be administered into the lungs. He therefore decided to intubate again. In order to insert a new tube a muscle relaxant was necessary. It was common cause that accused No 1 succeeded in inserting the second tube very quickly. The court found that accused No 1, when faced with the emergency acted swiftly. Accused No 2 at that stage 'froze' and accused No 1 had to take emergency measures to try and save the patient's life. It held that accused No 1 acted reasonably in trying to create an airway in the way in which he did and that even if it could be said that some other measure could have been taken to establish an airway without administering a further doze of scolene, accused No 1 could not be found to have been at fault for the way in which he acted in the situation of extreme emergency. Accused No 1 took all reasonable measures to resuscitate the deceased under the prevailing circumstances.

The court found that the state failed to prove that accused No 1 was negligent as alleged in the further particulars to the charge sheet or at all. In his opinion accused No 1 was therefore wrongly convicted. On behalf of accused No 2 it was submitted that the evidence was to a large extent uncertain and conflicting. It was, however, submitted that a certain period of time had elapsed from the

moment the oxygen mask was removed (which was used to oxygenate the patient with pure oxygen) until the time the first dark blood was observed. This lapse of time, it was argued, proved that the tube was initially correctly inserted. Therefore it was submitted that the fact that the tube was later found to be displaced, was not due to any fault on the part of accused No 2. It was further submitted that the tube must have been displaced by accused No 1. It was also submitted that everything which happened after it was discovered that the tube was displaced was irrelevant as nothing could have saved the deceased's life. According to the expert witness, Professor Cooper, if a tube of the correct length had been used and if it had been properly placed, it would not have slipped out of the trachea. Sister Lansdown was a person with long experience in nursing. From what she observed she was of the opinion that accused No 2 did not insert the tube correctly. Sister Lansdown testified as to the time lapse from the time that accused No 1 had begun operating on the patient until the dark blood was observed. According to her there was an insufficient lapse of time for the patient to have reached such an advanced state of deoxygenation that a darkening of the blood could have been caused. Accused No 2 also elected, as did accused No 1, not to testify. He therefore did not place on record the relevant time lapse. The estimates referred to on behalf of accused No 2 were derived from estimates given by Professor Cooper under cross-examination. The court observed that from the direct evidence of Sister Lansdown, who the court on the record as a reliable witness, the estimates of time relied on behalf of accused No 2 appeared to be incorrect. It held that the evidence for the state proved beyond reasonable doubt that the length of time from intubation till the blood turned dark is consistent with the tube not having been inserted properly and that the court *a quo* correctly found that accused No 2 failed to insert the tube correctly.

The court observed that from Professor Cooper's evidence it was clear that it was accused No 2's duty to monitor the deceased continuously and that it was possible for an anaesthetist to monitor a patient adequately using his senses and

simple apparatus such as a stethoscope and a blood pressure apparatus. The anaesthetist is therefore the person who will and must be able to detect an incorrectly placed or displaced tube. It found that accused No 2 did not at any stage whatsoever detect an incorrectly placed or misplaced tube. From the evidence it was clear that the condition of incorrect placement or displacement must have continued for a couple of minutes during which it should have been detected had accused No 2 performed his duties properly. The court stated that it was clear that the reason for monitoring a patient is to detect an insufficient supply of oxygen timeously and that early signs of an insufficient supply of oxygen can be detected by an increase of heartbeat, an irregular pulse rate and an increase of blood pressure. It held that there was therefore no merit in the argument that there was no evidence as to what symptoms should have been observed and that there was also no merit in the argument that there was no evidence as to when the symptoms would have been observed. Van der Merwe J held that even if it was wrong to find that the tube was initially incorrectly placed, accused No 2 could still be faulted for his failure to monitor the deceased properly and thereby detecting the misplacement of the tube timeously. This failure by accused No 2 led to the crisis which arose. On being told about the crisis accused No 2 'froze' and accused No 1 had to undertake resuscitation of the patient. He said that although accused No 2's failure to act promptly in the emergency might be frowned upon, it did not cause the death of the deceased as accused No 1 did whatever was possible. The court ruled that accused No 1's conviction and sentence must be set aside while accused No 2's appeal must be dismissed.

Discussion

The judgment in this case indicates what one would have thought is a fairly obvious principle in law – that one person cannot be held liable for another's wrongdoing in circumstances where there is no relationship of control or accountability between them. There is furthermore no duty upon one health

professional to assess the competence of another in a situation in which they are operating as a team and to act in a way that minimises the risk of any deficits in the skill or knowledge of the other professional. The court did say that there may be exceptions for instance in a situation in which the one doctor knows that the other is not fit to perform his duties or is incompetent[103]. It is submitted, however that this is a far cry from a duty to ensure that the other health professionals in the team are competent and sufficiently skilled since this is the duty of the relevant statutory professional body which is required to register them as such on sufficient proof of such professional skill and knowledge. The rule *imperitia culpae adnumeratur* cannot be applied to the team as such, i.e. to a group of individuals collectively. Each must stand on his own two feet in terms of his competence and skill to perform the work he has undertaken. Each member of the team is entitled to rely on the others to perform their roles correctly and effectively and they cannot be held jointly and severally liable for each other's mistakes.

Strauss makes the interesting point that depending upon the severity of the injury and the availability of better qualified professionals, a doctor, nurse or paramedic may in a case of dire emergency – where the patient is at death's door – attempt measures which go far beyond his or her training, competency or experience. He uses the actions of the surgeon in trying to save the patient in this case and assuming the role of the anaesthetist when the latter 'froze' as support for this conclusion. He points out that in cases of extreme emergency even unqualified laymen may render aid to the injured although it would be held unreasonable for a layman to treat a critically injured person if expert medical aid is immediately available.

---

103 Claassen and Verschoor (fn 5 *supra*) observe at p 109 that a physician can also be held liable where he knew, or by exercising reasonable care should have known, that one or the other practitioners committed an unlawful act and where he has allowed him to proceed without any objection. They note, however, that Strauss and Strydom (fn 16 *supra*) point out that in this case the practitioner's liability is based on his own negligence rather than that of his colleague. They also note at p 108 that where a practitioner is absent from his practice for a period of time and he has arranged for his patients to be treated by an independent ***locum tenens*** he will not normally be held liable for the negligent conduct of the ***locum tenens*** unless the relationship between them is one of employer/employee. Reasonable care must, however, be exercise in the selection of a ***locum tenens***.

The concept of scope of practice is a very important element of the lawful delivery of health care services in South Africa In terms of section 34 of the Health Professions Act[104], registration is a prerequisite for practising a profession in respect of which a professional board has been instituted[105].

Section 36 provides for penalties for practising as a medical practitioner or as an intern, or for performing certain other acts, while unregistered[106]. Penalties

---

104 Health Professions Act fn 7 *supra*

105 Section 34 provides that:

(1) Subject to the provisions of sections 33 (2) (c) and 39, no person shall practise for gain within the Republic any other health profession the scope of which has been defined by the Minister in terms of section 33 (1), unless he or she is registered in terms of this Act in respect of such profession.

(2) Any person who contravenes the provisions of subsection (1) shall be guilty of an offence and on conviction liable to the penalties mentioned in section 39.

106 Section 36 provides that:

(1) Subject to the provisions of subsections (2) and (3) and section 37 any person, not registered as a medical practitioner or as an intern, who-

(a) for gain practises as a medical practitioner (whether or not purporting to be registered);

(b) for gain-

(i) physically examines any person;

(ii) performs any act of diagnosing, treating or preventing any physical defect, illness or deficiency in respect of any person;

(iii) advises any person on his physical state;

(iv) on the ground of information provided by any person or obtained from him in any manner whatsoever-

(aa) diagnoses such person's physical state;

(bb) advises such person on his physical state;

(cc) supplies or sells to or prescribes for such person any medicine or treatment;

(v) prescribes or provides any medicine, substance or thing; or

(vi) performs any other act specially pertaining to the profession of a medical practitioner;

(c) except in accordance with the provisions of the Medicines and Related Substances Act, 1965 (Act 101 of 1965), the Pharmacy Act, 1974 (Act 53 of 1974), the Health Act, 1977 (Act 63 of 1977), the Nursing Act, 1978 (Act 50 of 1978), the Chiropractors, Homeopaths and Allied Health Service Professions Act, 1982 (Act 63 of 1982), and sections 33, 34 and 39 of this Act, performs any act whatsoever having as its object-

(i) the diagnosing, treating or preventing of any physical defect, illness or deficiency in any person; and

(ii) by virtue of the performance of such act, the obtaining, either for himself or for any other person, of any benefit by way of any profit from the sale or disposal of any medicine, foodstuff or substance or by way of any donation or gift or by way of the provision of accommodation, or the obtaining of, either for himself or for any other person, any other gain whatsoever;

(d) pretends, or by any means whatsoever holds himself out, to be a medical practitioner or intern (whether or not purporting to be registered) or a healer, of whatever description, of physical defects, illnesses or deficiencies in man;

(e) uses the name of medical practitioner, intern, healer or doctor or any name, title, description or symbol indicating, or calculated to lead persons to infer, that he is the holder of any qualification as a medical practitioner, physician or surgeon, or as an obstetrician or intern or of any other qualification enabling him to diagnose, treat or prevent physical defects, illnesses or deficiencies in man in any manner whatsoever, or that he is registered under this Act as a medical practitioner or an intern;

(f) except in accordance with the provisions of the Medicines and Related Substances Act, 1965, the Pharmacy Act, 1974, the Health Act, 1977, the Nursing Act, 1978, the [Associated] Chiropractors, Homeopaths and Allied Health Service Professions Act, 1982, and sections 33, 34 and 39 of this Act, by words, conduct or demeanour holds himself or herself out to be able, qualified or competent to diagnose, treat or prevent physical defects, illnesses or deficiencies in man or to prescribe or supply any medicine, substance or thing in respect of such defects, illnesses or deficiencies; or

(g) (i) diagnoses, treats or offers to treat, or prescribes treatment or any cure for, cancer;

(ii) holds himself out to be able to treat or cure cancer or to prescribe treatment therefor; or

(iii) holds out that any article, compound, medicine or apparatus is or may be of value for the alleviation, curing or treatment of cancer, shall be guilty of an offence and on conviction liable to a fine or to imprisonment for a period not exceeding twelve months or to both such fine and such imprisonment.

for practising as a psychologist or as an intern-psychologist, or for performing certain other acts, while unregistered are provided for in section 37 while section 38 provides for penalties for practising as a dentist, or for performing certain other acts, while unregistered. Section 39 prohibits the performance for gain of certain acts deemed to pertain to other health professions by unregistered persons registrable in terms of the Health Professions Act[107].

The Rules Specifying the Acts or Omissions In Respect of Which Disciplinary Steps May Be Taken By and Professional Board and the Council[108] state that one of the acts by a practitioner in respect of which such steps can be taken is the performance, except in an emergency, of professional acts for which the practitioner is inadequately trained and/or insufficiently experienced, and/or under improper conditions and/or in improper surroundings.

Section 27 of the Nursing Act[109] contains similar provisions in respect of persons practising as registered nurse, midwife, enrolled nurse or nursing auxiliary or for performing certain other acts while not registered or enrolled.[110]

---

107 Section 39 provides that:
(1) No person shall perform for gain any act deemed under section 33 to be an act pertaining to any other health profession unless he or she-
(a) is registered in terms of this Act in respect of such profession;
(b)(i) is registered in terms of this Act in respect of any other profession to which also such act is under section 33 deemed to pertain; or
(ii) practises another health profession in respect of which the registrar in terms of this Act keeps a register and such act is deemed to be an act which pertains to such professions registered under section 32 in respect of any other profession to which also such act is under section 33 deemed to pertain; or
(c) is a medical practitioner and such act is an act which also pertains to the profession of a medical practitioner;
(d) is a dentist and such act is an act which also pertains to the profession of a dentist; or
(e) is registered or enrolled as a nurse under the Nursing Act, 1978 (Act 50 of 1978), and such act is an act which also pertains to the profession of a nurse.
(2) Any person contravening the provisions of subsection (1) shall be guilty of an offence and on conviction liable to a fine not exceeding R500 or to imprisonment for a period not exceeding 12 months, or to both such fine and such imprisonment.

108 Government Notice No R.1329 dated 12 August 1994 in Government Gazette No 15907. Rule 29 also includes as an act subject to disciplinary action "the performance, except in an emergency, of professional acts where conditions calling for medical attention are observed or suspected, except in close collaboration with a medical practitioner."

109 Nursing Act fn 13 *supra*

110 Section 27 specified that:
(1) A person who is not registered or enrolled in a particular capacity-
(a) who makes use of a title which only a person who is registered or enrolled in that capacity may use, whether he makes use of such title alone or in combination with any word or letter;

In terms of section 41(1) of the Nursing Act, no remuneration shall be recoverable in respect of any act specially pertaining to the profession of a registered or enrolled person when performed by a person who is not authorized under this Act to perform such act for gain.

It is clear from the foregoing that -

- a layperson who acts as a health professional except in emergency situations where no health professional is present is breaking the law and runs the risk of criminal prosecution;
- a health professional who, except in emergency circumstances, exceeds the scope of practice for which he or she is registered is breaking the law and runs the risk not only of criminal prosecution but also disciplinary action by the relevant professional body (the Nursing Act states expressly in section 27(4) that the provisions of subsection 2(a) and (b) which render it an offence to perform for gain an act pertaining to the profession of nursing or midwifery, do not apply with reference to a person rendering assistance in a case of emergency. Similarly section 38(3) of the Health Professions Act provides that nothing in section 38 shall be construed as prohibiting a medical practitioner, not registered also as a dentist, from

---

(b) who holds himself out or permits himself to be held out, directly or indirectly, as being registered or enrolled in that capacity; or
(c) who wears a uniform, badge or other distinguishing device, or any misleading imitation thereof, prescribed in respect of a person registered or enrolled in that capacity,
shall be guilty of an offence.
(2) Subject to the provisions of subsection (4) and the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974), a person-
(a) who is not registered as a nurse or enrolled as a nurse or a nursing auxiliary and who for gain performs any act pertaining to the profession of nursing;
(b) who is not registered or enrolled as a midwife and who for gain performs any act pertaining to the profession of midwifery; or
(c) who is not registered or enrolled as a midwife and who makes any internal examination of the genitals of a woman while attending to the woman in relation to a condition arising out of or in connection with pregnancy,
shall be guilty of an offence.
(3) A person who, knowing that another person is not registered or enrolled in a particular capacity-
(a) describes such person as the holder of a title which only a person who is registered or enrolled in that capacity may use, whether he describes such other person by making use of such title alone or in combination with any word or letter; or
(b) holds such other person out, directly or indirectly, as being registered or enrolled in that capacity, shall be guilty of an offence.

performing in the course of his practice acts pertaining to the practice of dentistry in cases of emergency or where no dentist is readily available.)

Generally speaking the law allows acts and omissions in an emergency that it would not otherwise allow and it is submitted that generally speaking, health professionals would be relatively safe from legal threat in acting outside of the scope of their practice in an emergency situation provided that they act reasonably and only to the extent necessary to remedy the situation. It should be borne in mind, however, that whether or not the situation involved an emergency can in itself be a tricky question to answer. The problems with the definition of an emergency situation in the context of health services delivery have been discussed in more detail elsewhere in this thesis. It is sufficient for present purposes to note that if the health professional in question reasonably believed the situation to be an emergency and acted in order to address the perceived threat, he or she should not be penalised for that reasonable belief if the situation was subsequently found not to be an emergency. It is easy to be wise after the event in the relative calm of a courtroom but a tendency to judge too harshly someone who has acted with the best of intentions in the genuine and reasonable belief that a situation was an emergency is likely to result in an undesirable reluctance or unwillingness on the part of health professionals to act except in the most obvious emergency situations. This would not be consistent with the spirit of the constitutional provision that no one should be refused emergency medical treatment.

The question of when, if ever, a health professional may exceed his or her scope of practice in non-emergency situations in the course of routine activities in the health sector is another matter. The public sector in South Africa is critically short of many different kinds of health professionals including nurses, pharmacists, general medical practitioners and specialists and especially in the rural areas. What is the position of a single nursing sister operating a clinic in the middle of nowhere who is faced with a situation in which a person comes to

the clinic seeking medical assistance and the assistance that is required falls outside of her scope of practice as a nurse? The situation is not an emergency but could become one if she does not render the required assistance and there is no transport available to the nearest facility where there is a practitioner available within whose scope of practice the required treatment falls.

Section 38A of the Nursing Act anticipates this situation to a significant extent. It states that:

"Notwithstanding the other provisions of this Act and the provisions of the Medicines and Related Substances Control Act, 1965 (Act 101 of 1965), of the Pharmacy Act, 1974 (Act 53 of 1974), and of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974), any registered nurse who is in the service of the Department of Health, Welfare and Pensions, a provincial administration, a local authority or an organization performing any health service and designated by the Director-General: Health, Welfare and Pensions after consultation with the South African Pharmacy Board referred to in section 2 of the Pharmacy Act, 1974, and who has been authorized thereto by the said Director-General, the Director of Hospital Services of such provincial administration, the medical officer of health of such local authority or the medical practitioner in charge of such organization, as the case may be, may in the course of such service perform with reference to-

(a) the physical examination of any person;
(b) the diagnosing of any physical defect, illness or deficiency in any person;
(c) the keeping of prescribed medicines and the supply, administering or prescribing thereof on the prescribed conditions; or
(d) the promotion of family planning,

any act which the said Director-General, Director of Hospital Services, medical officer of health or medical practitioner, as the case may be, may after consultation with the council determine in general or in a particular case or in cases of a particular nature: Provided that such nurse may perform such act only whenever the services of a medical practitioner or pharmacist, as the circumstances may require, are not available."

The proviso is important. It is only in the absence of the services of a medical practitioner or pharmacist that the activities listed in section 38A may be performed by a nurse. The authority can be specific or general and the section can apply in respect of the public sector or the private sector. In practice it is submitted that it is unlikely to be applied in the case of the private sector unless there are no nearby public sector facilities available to deliver the required service either. This section certainly is not a license to nurses to act as they see

fit in circumstances where there is no medical practitioner or pharmacist since it requires the authorisation of the Director General, a director of hospital services a medical officer or medical practitioner and that authorisation is only given after consultation with the relevant council.

Generally speaking, however, it is submitted that except in cases of emergency, section 27 of the Constitution does not sanction the provision of medical treatment by persons who are unqualified to do so and who do not have the necessary skills and experience. The shortage of health care professionals in the public sector is a problem that needs to be addressed by the South African government under the auspices of section 27(2) of the Constitution which require it to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right of access to health care services. As stated previously access in this context cannot be interpreted to mean access to health care services that do not meet with certain minimum standards of quality, safety and efficacy.

Claassen and Verschoor[111] observe that the question often arises whether a practitioner can be held liable for the conduct of physicians nurses and professional assistants employed by a hospital authority but who are assisting the independent practitioner in the treatment of his patients on the hospital premises. Are the said staff members in such an even still regarded as employees of the hospital or are they regarded as servants of the independent practitioner *pro hac vice*? They note that according to Holder, a surgeon is not liable for the negligent routine conduct performed by the hospital staff in preparing a patient for an operation. They same goes for the conduct of hospital staff after the completion of an operation because the surgeon can reasonably accept that they are competent to perform their duties. A surgeon can however, be held directly responsible where he leaves negligent instructions regarding the post-operative care of a patient to the hospital staff. Claassen and

111 Claassen and Verschoor fn 5 *supra*

Verschoor[112] note that some American courts have applied the so-called *captain of the ship doctrine* in order to resolve some of the issues raised above. According to this doctrine, the surgeon is responsible for everyone who assists him during an operation. It was argued that the surgeon, as captain of the ship, exercised absolute control over every aspect of a particular procedure. They note that the captain of the ship doctrine was finally sunk in *Sparger v Worley Hospital Inc*[113] when the court remarked:

"We disapprove if the captain of the ship doctrine and hold that it a false special rule of agency. Operating surgeons and hospitals are subject to the principles of agency law which apply to others."

It is the view of the writer that this is a doctrine well sunk and that it has no place in South African law. Claassen and Verschoor also discuss the borrowed servant doctrine which acknowledges the fact that a particular employee can be borrowed by one employer from another to perform a certain task which is in the interests of both employers and influences their common objectives. They note that Strauss and Strydom point out that the idea of borrowed servants was introduced to South African law in the decision of *Hartl v Pretoria Hospital Committee*[114] but that it was rejected unambiguously in *Van Wyk v Lewis*[115] by ruling that a visiting surgeon was not liable for the failure of a hospital nurse to perform an independent duty. They note that according to Burchell and Schaffer[116] the relationship between a surgeon and a nurse cannot be equated to that existing between an employer and employee and it is not even analogous thereto even if the nurse may have been under the control of the surgeon during the operation. These authors contend that although the nurse is under the control of the physician during the performance of the operation, the hospital never turns over its full right to exercise control over its employees to an independent practitioner. The nurse remains in the hospital's employment and

112 Claassen and Verschoor fn 5 *supra*
113 *Sparger v Worley Hospital Inc* 547 SW 2d 582 Tex 1977
114 *Hartl* 1915 TPD 336
115 *Van Wyk* fn 24 *supra*
116 Burchell JM and Shaffer RP 1977 'Liability of Hospitals for Negligence' *Businessman's Law* 6(4): 109-111

any loss suffered by a patient as a result of the former's negligent conduct should be placed on the broad shoulders of the hospital authority. It is submitted with respect that this is the correct view since it accords with the South African case law on the subject, notably the decision in *Van Wyk v Lewis*.

It must be noted that in the public sector doctors are usually employees of the state just like the nurses and other health professionals they work with. Questions of this nature are therefore more likely to arise in the private sector context where, although nurses and professional assistants may well be employed by the hospital, medical practitioners tend to be self-employed.

8.2.9 Pringle v Administrator, Transvaal [117]

Facts

The plaintiff instituted a claim for damages against the Administrator of the Transvaal, being the representative of the Transvaal Provincial Administration, under whose jurisdiction the J G Strijdom Hospital fell. On 5 October 1984 an operation was performed upon the plaintiff at the J G Strijdom Hospital by Dr Schewitz duly assisted by Drs Scoccianti, Reidy and Lever. These medical practitioners were acting within the course and scope of their employment with the J G Strijdom Hospital and/or the Transvaal Provincial Administration.

The plaintiff alleged that the medical practitioners had a duty of care to perform the operation with the requisite degree of skill and expertise, but in breach thereof one or more or all of the medical practitioners performed the operation negligently in that:

---

117 *Pringle* 1990 (2) SA 379 (W)

(i) the plaintiff's superior vena cava was torn during the course of the operation;

(ii) the medical practitioners failed to detect the tear in the plaintiff's superior vena cava at a time when they could and should have done so;

(iii) they failed to appreciate that the tumour being removed was attached to the superior vena cava and that its removal could result in the severing of the vena cava unless special precautions were taken;

(iv) they failed to test whether the removal of the tumour would result in excessive loss of blood under circumstances in which they could and should have done so;

(v) they failed to detect that the plaintiff was losing an excessive amount of blood at a time when they could and should have done so;

(vi) they failed to avoid the consequences which resulted when, by the exercise of reasonable care and skill, they could and should have done so;

(vii) that, once haemorrhaging occurred during the operation, they failed to proceed immediately with sternotomy or right thoracotomy in order to stabilise and prevent further or recurrent bleeding.

In the alternative to the aforegoing it was pleaded that the medical practitioners owed a duty of care to the plaintiff to perform the correct and/or appropriate surgical procedure, but in breach of that duty the medical practitioners performed a surgical procedure called 'mediastinoscopy', which was neither correct nor appropriate.

It was alleged that one or more or all of the medical practitioners were negligent in that they failed to warn the plaintiff that the operation in question had a high morbidity rate.

The plaintiff claimed that as a consequence of their negligence she suffered brain damage which has resulted in permanent damage to her eyesight and her

permanent inability to work. She claimed damages in the sum of R97 228 made up as follows:

(a) Loss of earnings at R950 per month for a period of seven years -R77228

(b) General damages for pain and suffering, shock, loss of amenities of life and disablement - R20000

Total- R97 228

At a pre-trial conference held on 29 July 1988 certain admissions were made and certain agreements arrived at:

(a) Dr Schewitz performed the bronchoscopy and mediastinoscopy by himself in the presence of two anaesthetists.

(b) Dr Scoccianti and Dr Sishy were present at the second operation and Dr Conlan came into the theatre when the mediastinum was packed.

(c) The defendant admitted the operation report prepared by Dr Schewitz dated 5 October 1984 without formal proof, as also the operation record.

(d) It was admitted by the defendant that the plaintiff's superior vena cava was torn during the initial operative procedure, i.e. the mediastinoscopy.

(e) It was also admitted that the plaintiff suffered brain damage as a result of the operation.

(f) It was admitted that the thoracotomy was commenced at approximately 12:30 and was concluded at approximately 13:30.

(g) The defendant was prepared to admit the correctness of the actuarial calculations done by Mr G W Jacobson but was not prepared to admit the correctness of the assumptions on which such calculations were based.

(h) The defendant admitted that the X-rays were taken in the resuscitation room at some time between 12:10 and 12:30.

The medical expert witnesses who were to be called by each side met for a medical pre-trial conference as a result of which a minute was handed in, the salient points of which are as follows:

(i) The patient had a previous history of carcinoma.

(ii) The patient presented with opacity of the right lung.

(iii) An investigation of the mass of the right lung was necessary.

(iv) There was no unanimity amongst the medical experts in regard to which procedure should have been followed. The type of operation to be performed is a matter of personal choice for the surgeon performing the operation.

(v) During the course of the mediastinoscopy procedure performed by Dr Schewitz, the patient's superior vena cava was torn as a result of which torrential bleeding occurred.

(vi) The mediastinum was packed. The plaintiff lost approximately two litres of blood, and a right thoracotomy was performed to repair the damaged vena cava.

(vii) After the mediastinum was packed there was a time-lag before the thoracotomy was performed. There was a dispute between the medical experts on the reasonableness of the delay which occurred between the first and second operative procedures.

(viii) The plaintiff went into renal failure and suffered localised brain damage which has resulted in a permanent visual disability.

The plaintiff testified that she was not told what was involved in the operation, but if she had been told that the operation was serious, she would have thought about it and possibly even obtained a third opinion. She testified that before the operation she had lived a very full and busy life, baking, icing cakes, knitting clothes, sewing and gardening. She drove a car and was completely independent. After the operation she was unable to work and could also no longer drive a car. A number of witnesses testified to the change in the personality and character of the plaintiff post-operatively as compared to the person she was prior thereto.

Judgment

The court held that there was no room for the application of the maxim *res ipsa loquitur* on the strength of the decision in *Van Wyk v Lewis*[118] saying that the maxim could only be invoked where the negligence alleged depends on absolutes. In *Pringle* the initial problem was caused by the perforation of the superior vena cava. The court said that if the evidence showed that by the mere fact of such perforation negligence had to be present, then the maxim would have application. It found that no such evidence, however, had emerged and that since the question of whether negligence was present or not depends upon all the surrounding circumstances, this makes the application of the maxim 'totally inapplicable in cases such as the present.'

The court observed that in determining what standard of diligence it was the surgeon's duty to observe, the law in South Africa was clearly stated in *Van Wyk v Lewis* - a medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but his is bound to employ reasonable skill and care. Blum AJ noted that in deciding what is reasonable the court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs. He referred to the English case of *Whitehouse v Jordan*[119] in which Lord Edmund Davies referred to McNair J in *Bolam v Friern Hospital Management Committee*[120], where the latter said:

"Where you get a situation which involves the use of some special skill or competence then the test as to whether there has been negligence or not is not the test of the man on the top of the Clapham omnibus because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill."

---

118 *Van Wyk* fn 24 *supra*
119 *Whitehouse* [1981] 1 All ER 267 (HL)
120 *Bolam* [1957] 2 All ER 118 at 121

Also with regard to the standard of diligence and skill to be applied, Blum AJ referred to *S v Kramer and Another*[121]

Dr Schewitz noted that the plaintiff had had a mastectomy for carcinoma of the breast 29 years previously. Following an incidental chest X-ray a small nodule was noted in the right chest. The first procedure which was performed was a bronchoscopy which was normal in all respects. However, while the mediastinoscopy was being performed torrential venous bleeding occurred when the right paratracheal node was biopsied. As a result of this bleeding the mediastinum was packed for ten minutes, following which the bleeding had stopped. The plaintiff at this stage had lost approximately 200cc of blood. The mediastinum was packed with surgical and the wound closed. A chest X-ray taken following the procedure while the plaintiff was still in theatre showed that the plaintiff had bled into the right chest. The plaintiff's blood pressure had also dropped, and she was immediately brought back to the theatre where a right thoracotomy over the fifth rib was performed. During this procedure it was found that the superior vena cava had been torn 1 cm above the azygos vein. There were also two litres of blood in the chest. The rupture of the superior vena cava was repaired. The phrenic nerve, which was right next to the tear, had been damaged. Subsequently Dr Schewitz testified that in fact this nerve was not damaged. The nodule was found in the upper lobe and was typical of a benign lesion. A wedge resection on the nodule itself was performed with the nodule being sent for histology and which was indeed confirmed to be benign. Two chest drains were inserted and the wound was closed in layers. Post-operatively the plaintiff was returned to the intensive care unit for observation, although she did not need ventilation. From the hospital records it appears that the plaintiff went into acute renal failure the following day and required haemodialysis.

---

121 *Kramer* 1987 (1) SA 887 (W) at 893E - 895C.

The plaintiff alleged that the procedure adopted, namely the mediastinoscopy, was neither correct nor appropriate. There was no unanimity amongst the experts with regard to which procedure should have been followed. The doctors agreed that the type of operation to be performed is a matter of personal choice for the surgeon performing the operation. Blum AJ posed the question whether in this light of this it could possibly be said that the procedure selected by Dr Schewitz was either incorrect or inappropriate? After discussing the various expert evidence that was placed before it, the court decided that the plaintiff had not discharged the onus of proving that the procedure was neither correct nor appropriate. It said that the procedure adopted was clearly a matter of personal choice.

It was common cause that the cerebral defect was caused by some loss of blood to the vital organs at some time after the superior vena cava was torn and until it was sutured. In other words, plaintiff suffered an occipital lobe thrombosis. After considering the evidence the court held that in the final analysis it was not satisfied that the plaintiff had shown on a balance of probabilities that if the medical practitioners had proceeded to do a thoracotomy immediately the damage would not have been done, and that consequently any delay which occurred through waiting for X-rays before making a diagnosis was unreasonable and therefore negligent. With regard to the allegation that the medical practitioners failed to appreciate that the tumour being removed was attached to the superior vena cava and that its removal could result in the severing of the vena cava unless special precautions were taken the court noted that Dr Schewitz stated quite categorically that in this regard the mass was in the lung. The gland in the mediastinum which was to be excised was not attached to the superior vena cava. Accordingly Blum AJ held that this ground of negligence must fail.

Another allegation of negligence was that the medical practitioners failed to warn the plaintiff that the operation in question has a high morbidity rate. The

court stated that from the evidence it was clear that the procedure preferred by Dr Meintjes had a higher morbidity rate, and that in mediastinoscopy the morbidity rate is recognised as being low. Consequently it held that there was therefore no substance in this allegation.

The very vexed and difficult question, however, which remains to be decided, is whether the fact that the plaintiff's superior vena cava was torn during the course of the said operation, and that the plaintiff lost an excessive amount of blood into the pleural cavity as a result of the tearing, not only of the superior vena cava but of the mediastinal pleura, amounts to negligence.

Blum AJ, apparently oblivious of the fact that he had stated earlier in the judgment that the maxim of *res ipsa loquitur* was not applicable, observed with reference to the minority judgment of Kotze JA in *Van Wyk v Lewis*[122] that it has been stated that, where a plaintiff has proved certain facts from which, if not satisfactorily rebutted or explained, the conclusion may reasonably be drawn that there has been an absence of the necessary care and skill on the part of the medical man, a case of negligence against the defendant has been established, rendering him liable in damages. He noted the difficulty of the case and then commented that as to the crucial issue as to exactly what happened there was only the direct evidence of Dr Schewitz. Blum AJ noted that in cross-examination it was put to Dr Schewitz that the tearing of the vena cava was negligent. He replied that an event such as this had happened in the hands of the most experienced surgeon, and he did not think that one could call a complication a mistake or negligence. Blum AJ also noted that Dr Kinsley said, in his view, there was no question of negligence in the management of the case. He also did not agree with the proposition put to him that there was simple negligence by the surgeon. It is, however, said Blum AJ a matter for the Court and not the expert witnesses to determine whether there has been negligence or not. He then asked whether it could be said that the surgeon committed an error

---

122 *Van Wyk* fn 24 *supra* at p 452

of clinical judgment? Referring to the *Whitehouse* case[123] *supra*, Blum AJ noted that Lord Edmund Davies said:

'To say that a surgeon committed an error of clinical judgment is wholly ambiguous, for while some such errors may be completely consistent with the due exercise of professional skill, other acts or omissions in the course of exercising clinical judgment may be so glaringly below proper standards as to make the finding of negligence inevitable.'

He observed that there was no suggestion that any act or omission by Dr Schewitz was so glaringly below proper standards as to make a finding of negligence inevitable. But, said Blum AJ in considering the statement by Lord Edmund Davies previously quoted that if a surgeon fails to measure up to that standard in any respect ("clinical judgment" or otherwise), he has been negligent and should be so adjudged and in attempting to determine whether in fact Dr Schewitz failed that test or not, the only evidence which is of assistance is the evidence of Dr Schewitz himself. Dr Schewitz stated that the biopsy did not bite cleanly and that he tugged at it, bleeding occurred and he immediately let go of the tissue to decrease the bleeding. The court noted that in cross-examination it was put to him that he 'tugged' at the lymph-node and pulled the vena cava. His answer to this was: 'In retrospect I would have to say that I tugged too hard.' He agreed furthermore with the proposition that once the bleeding had occurred he appreciated that he had torn a major vessel and that it could conceivably be the superior vena cava with possible dire consequences. He agreed further that the paratracheal gland which was to be excised, where it was situated was adjacent to the superior vena cava but not attached to it, and that its texture is different from the vein itself and possible to distinguish. Once again he stated: 'There must have been excessive force because the event occurred. I am more experienced and it makes a similar event unlikely.' Blum AJ stated that in deciding whether Dr Schewitz, in attempting to excise the nodule in the manner in which he did, employed reasonable skill and care, and applying the test as set out by Innes CJ in Van Wyk's case *supra*, he took into

123 *Whitehouse* fn 119 *supra* at p 276H

consideration the fact that the mediastinum is a confined area in which there are certain major vessels, the superior vena cava being one of them. He said that it may be described as a surgical minefield. The gland in which the excision was to take place was adjacent to the superior vena cava. Had the forceps excised the nodule cleanly, no doubt the claim would not have arisen. He observed that there was no explanation as to how or why the forceps did not 'bite cleanly', in Dr Schewitz's words. He then tugged at the gland in order to make the nodule come away, and the bleeding occurred immediately. Not only was the superior vena cava perforated, but the blood found its way through the mediastinal pleura, which was also torn, into the pleural cavity.

Dr Kinsley testified in regard to the tearing of the superior vena cava that this could only have happened in two ways. It was either biopsied directly or torn indirectly through traction on the gland. Either eventuality, said Blum AJ, caused him concern. He observed that the biopsy forceps is a cutting instrument, but since it did not cut through the gland it would appear that the tissues were more leathery or fibrous. Dr Kinsley explained that in elderly persons, and females particularly, the superior vena cava is usually more friable than in other persons. He postulated the possibility that because of radiotherapy in earlier years when the plaintiff had the mastectomy, the superior vena cava may have become more friable while the tissues became more leathery.

Blum AJ referred to *Bochris Investments*[124] in which the court cautioned against the insidious subconscious influence of *ex post facto* knowledge. He stated that negligence is not established by showing merely that the occurrence happened (unless the case is one where *res ipsa loquitur*), or by showing after it happened how it could have been prevented. He observed that the diligens paterfamilias does not have "prophetic foresight" and noted that in *Overseas Tankship (UK) Ltd v Morts Dock and Engineering Co Ltd (The Wagon Mound)*[125] Viscount

---

124 *S v Bochris Investments (Pty) Ltd* 1988 (1) SA 861 (A) at p 866I - 867C

125 *Wagon Mound* 1961 AC 388 (PC) ([1961] 1 All ER 404 at 424 (AC) and 414G - H (in All ER)

Simonds said: "After the event, even a fool is wise. But it is not the hindsight of a fool; it is the foresight of the reasonable man which alone can determine responsibility."

Blum AJ said that he was mindful of the test of foreseeability which had to be applied, namely: ought Dr Schewitz to have reasonably foreseen that if excessive force was used to excise the lymph-node, damage could be caused, more particularly to the superior vena cava? He noted that the evidence was that the perforation of the superior vena cava is one of the recognised complications of mediastinoscopy, albeit, in Dr Kinsley's view, of rare occurrence. He said he was also mindful of all the pressures and the tensions which operate on a surgeon during his work. However, in the light of all the evidence and the only possible explanations as to how the perforation of the superior vena cava and the mediastinal pleura occurred, he said he was driven to find that on this particular aspect, and by using the 'excessive force' which he conceded, Dr Schewitz did not apply that skill and diligence possessed and exercised at the time by the members of the branch of the profession to which he belonged. He held that in tearing the superior vena cava, while attempting to biopsy the lymph-node in the gland adjacent thereto, Dr Schewitz was negligent.

In considering the quantum of damages, Blum AJ took into account the fact that the plaintiff was sixty three at the time of the operation and had reached the age of sixty seven and a half at the time of trial, without further incident. He said that her life expectancy has not been reduced as a result of the incident. Judging from the plaintiff's general work record and her health up to the time of the present incident, even having regard to the fact that she had a mastectomy in 1955, and having further regard to the various factors which courts take into account in assessing accrued loss, Blum AJ was of the opinion that a 5% contingency deduction was fair and reasonable, and accordingly found that the plaintiff's accrued loss of income amounted to R43 178. Insofar as prospective loss is concerned, again having regard to unforeseen contingencies for the next

three years it was Blum AJ's opinion that a contingency deduction of 15% was fair and reasonable, and thus the amount of the plaintiff's prospective loss was R34 305.Accordingly he awarded judgment in favour of the plaintiff in the sum of R93 482 and costs, including the qualifying fees of Dr Meintjes and Mr G W Jacobson.

Discussion

Pringle's case illustrates rather well the difficulties faced by a patient who is trying to prove medical negligence. It was abundantly clear that Blum AJ experienced intense difficulty in coming to a decision in this case and that the fact that *res ipsa loquitur* could not be applied only added to this difficulty. He pointed out several times in the course of the judgment that the only significant evidence as to what happened during the surgery was that of the surgeon himself. He clearly went through the evidence with a fine toothcomb hoping to find some indication as to which way his decision should go. At one point, when he referred to the judgment of Kotze JA in *Van Wyk v Lewis* it almost seemed as though he was wishing subconsciously or even consciously that he could apply the *res ipsa loquitur* maxim. The basis upon which Blum AJ came to the conclusion that the doctor in *Pringle* had been negligent was scant indeed. On the evidence available from the judgment, it seems quite clear that the court's decision could just as easily have gone the other way. Whilst the surgeon may have made a mistake or an error of judgment in pulling too hard, this in and of itself does not signify negligence. He could not necessarily have foreseen that this would tear the vena cava. How hard is too hard? In layman's terms it may be the coarse difference between a gentle tug and a ripping motion but in a surgeon's terms it may be the very fine difference between a gentle tug and a gentler tug. In fact, the tear in the vena cava was small by all accounts. According to the judgment, the bleeding was controlled by one prolene suture, which, the court observed, is 'fairly small'. There was much evidence that even an experienced surgeon could have made the same mistake. The surgeon was

not even in a position to know that he had torn the vena cava after the event. Blum AJ observed that it seemed clear from the evidence that, because of the blood that welled up in the mediastinum and the apparent subsidence thereof once it was plugged by surgical, the medical practitioners, and more particularly Dr Schewitz, were not in a position at that stage to detect that there had been a tear in the plaintiff's superior vena cava. The fact that the harm even once it had been done was far from obvious tends to suggest that the force used by the surgeon to tug on the tissue he was trying to remove may also not foreseeably have led to a tear in the vena cava. It is submitted that the statements of the surgeon upon which the court relied in deciding for the defendant are indicative of causation rather more than negligence. Dr Schewitz said 'In retrospect I would have to say that I tugged too hard' and 'There must have been excessive force because the event occurred. I am more experienced and it makes a similar event unlikely.' If one analyses these statements more closely it is obvious –

(a) that they are conclusions drawn after the event by the doctor and are not reflections on his actions at the time of the surgery;
(b) that they are conclusions based upon the fact that the vena cava tore;
(c) that they are conclusions as to the cause of the tear in the vena cava rather than negligence with regard to his actions that led to the tear.

Indeed in cross-examination it was put to Dr Schewitz that the tearing of the vena cava was negligent. He replied that an event such as this had happened in the hands of the most experienced surgeons, and he did not think that one could call a complication a mistake or negligence. It is submitted that, at least from the evidence supplied in the judgment itself, there was no proof of negligence on a balance of probabilities. Blum AJ himself admitted in the judgment 'that there is no suggestion that any act or omission by Dr Schewitz was so glaringly below proper standards as to make a finding of negligence inevitable.' It is submitted, albeit on the strength of the judgment alone, that it would seem that in Pringle's case there was proof only of a medical accident. One must of course heed the warnings of Blum AJ about being wise in retrospect and obviously all of the evidence is not available in the judgment.

The point is simply that Pringle's case seems to be a very good example of a borderline situation in which the court essentially had to make a 'judgment call' in the colloquial sense. It had to come down on either one side of the fence or the other and in Pringle's case it came down on the side of the plaintiff. Given the difficulty experienced by the court, how much more difficult, one might ask, is the position of the plaintiff who may only have access to all of the relevant information for the first time in the course of litigation in seeking to prove all of the elements of a delict that occurred at a time when she was unconscious. How wrong is it to allow a plaintiff in such circumstances the small concession permitted by the *res ipsa loquitur* principle? In Pringle's case she went into hospital without a torn superior vena cava, she went into the operating theatre without a torn vena cava, and she came out of the operating theatre with a torn vena cava. The operation she had did not involve her vena cava directly. The perforation of her vena cava was not a normal event in the course of the operation. Indeed, according to the evidence from the judgment, it was quite a rare complication. The small shift of the evidentiary burden that would have been permitted in terms of the *res ipsa loquitur* in this case should not have worked any grave injustice to the defendant who was in possession of all the facts and in the case of Dr Schweitzer witnessed the whole sequence of events first hand. One has to wonder whether the fact that the defendant was an institution, and a large one at that, may have had any bearing on the court's decision and whether if it had been a private practitioner this would have had any bearing on the outcome. Put another way and in a slightly different context, one also has to wonder whether the court felt that the balance of power in terms of knowing exactly what had happened was in favour of the defendant and that for this reason, it favoured the plaintiff. There does not seem to have been sufficient evidence on a balance of probabilities that there was negligence on the part of the doctors involved. Indeed one has to wonder whether the judgment in Pringle's case was not due to the indirect application by the court of the maxim of *res ipsa loquitur* in nebulous form and subconscious fashion.

In light of the fact that the test for medical negligence is the general principal that the highest degree of professional skill and knowledge is not required of a medical practitioner but only a reasonable level of knowledge and skill, Carstens[126] poses the question whether a medical practitioner who entertains a different school of thought concerning the medical treatment that should be applied would be negligent if he deviates from the generally accepted technique used by other medical practitioners in operations or treatment. He says it can also be asked what the position would be if there is more than one school of thought in respect of the type of treatment that a patient ought to receive. Carstens notes that in South African positive law direct authority could not be found concerning the concept of different schools of thought within medical practice and its influence on medical negligence. Carstens asks whether, if there is more than one school of thought concerning the nature of the treatment a patient ought to receive, is the doctor bound to that standard of practice which is applied by practitioners of that school of thought to which he subscribes? He refers to *Kovalsky v Krige*[127] in which a doctor tried to stop the bleeding following on from a circumcision by using ferrous chloride and other doctors gave evidence that they would have used other methods – specifically the use of arterial clamping and tying off. The defendant doctor was not held liable in this case. With regard to the decision in *Pringle*, he notes that the choices between different diagnostic techniques came into the debate. The court in this case had to rely heavily on expert medical testimony and in the pretrial conference there was no agreement between the medical experts as to the process or method that should have been used. It was agreed that the surgeon who had to do the operation could exercise his own personal preference concerning the execution of the operation. The court came to the conclusion that the plaintiff had not discharged the onus of proving that the surgical method or technique used by the surgeon was an incorrect or unsuitable procedure. In Carstens' opinion the

126 Carstens PA 'Nalatigheid en Verskillende Gedagterigtings ('Schools of Opinion) Binne Die Mediese Praktyk: *Pringle v Administrator Transvaal* 1990 (2) SA 379 (W)' 1991 *THRHR* 673.

127 *Kovalsky* 1910 CTR 822

general guidelines in respect of the recognition of different schools of thought within the practice of medicine should not be rigidly applied in the adjudication of professional liability where a procedure or technique is used that is not in accordance with the usual medical practice. He says that the application of a deviating practice by a doctor does not necessarily indicate negligence and points out that each case has to be considered with regard to its particular circumstances. He points out that the practice of medical science is inherently risky and that rigid application of the general guidelines could have an inhibitory effect on the effective development or application of new medical procedures which are necessarily experimental in nature and which carry the risk of possible harmful consequences for the patient. He states that the general guidelines should not be applied in a manner that places a damper on the renewal and improvement of medical procedures provided that such procedures are medically responsible and reasonable. The present writer respectfully concurs with these views. Where a number of different but equally legitimate and acceptable or recognized options are open to the reasonable provider, he or she cannot be blamed for using one that is less commonly used than the other. It is submitted that the reasonable doctor does not necessarily follow the most wellworn paths of medical science but uses instead those techniques and procedures which in his or her professional judgment carry the highest likelihood of success.

8.2.10 *Collins v Administrator, Cape* [128]

Facts

The plaintiff sued for damages both in his personal capacity and in his capacity as father and natural guardian of his minor daughter, Lee-Ann. The action was a sequel to a tragic incident which occurred at the Tygerberg Hospital on 21 October 1991, when Lee-Ann suffered severe cerebral hypoxia following the

[128] *Collins* 1995 (4) SA 73 (C)

displacement of a tracheostomy tube on which she was dependent for ventilation. At the time she was barely 16 weeks old. As a result of irreversible brain damage she was in what is described as a permanent vegetative state. Although her brainstem function was sufficient to maintain adequate ventilation and circulation she had no intellectual function. She had no awareness of environmental stimuli and no apparent awareness of herself. There was no hope of recovery and she would in all probability die within the next few years. Two questions required determination. The first was whether the mishap was attributable to the negligence of any of the members of the hospital staff who were involved in the care of Lee-Ann at the relevant time. The second, which arose only if the answer to the first was in the affirmative, was the quantum of damages to which the plaintiff was entitled. It was common cause that at all relevant times the members of the hospital staff were acting in the course and scope of their employment with the defendant.

Lee-Ann was born on 26 June 1991. Shortly after her birth she was observed to have a respiratory problem and she was immediately intubated with an endotracheal tube. Subsequent and more detailed examination revealed swelling of the vocal chords and the supraglottis. After 16 days there was no improvement and on 12 July 1991 a tracheostomy was performed. It was common cause that the procedure was mandatory at that stage. It involved establishing a portal in the trachea with the insertion of a neonatal tracheostomy tube. The object was to create an airway below the larynx and so bypass the obstruction in the larynx. The tube was made of a plastic material. The portion which actually enters the trachea was 30 mm in length, slightly curved and flexible. The external part of the tube had a flange with islets on either side, through which a tape was passed and tied around the patient's neck. The tension of the tape around the patient's neck is of vital importance to ensure that the tube remains in position. One of the grounds of negligence relied upon by the plaintiff was that the tension of the tape was inadequate.

Following the tracheostomy, Lee-Ann was first placed in the neonatal intensive care unit for a few days and thereafter, on 16 July 1991, moved to the paediatric tracheostomy unit which was a high care unit as opposed to an intensive care unit. Upon examination on 20 August 1991 it was found that the swelling had subsided but that she had an infantile, omega-shaped, epiglottis which at that stage remained non-functional. She was, therefore, still wholly dependent upon the tracheostomy tube for ventilation, but the prognosis was a good one. A number of nurses attached to the paediatric tracheostomy unit gave evidence. They all said that it was standard practice to check the tension of the tape holding the tracheostomy tube in place whenever anything was done to the patient, whether it be the clearing of the trachea, the cleaning of the tracheostomy site or anything else. This, they said, was effected, first by ensuring that nothing larger than a little finger could be inserted between the tape and the back of the patient's neck and, secondly, by drawing the flange of the tube away from the neck anteriorly to ensure that there was not too much 'play'. Many of the nurses were unable to explain why it should be necessary to constantly check the tension of the tapes, but they were all very conscious of the need for the tension to be correct. Dr Gie explained that provided the knot tying the two ends together does not slip, the tension would not vary. He said that every Thursday the tracheostomy tube of every patient in the unit was changed and unless the knot came undone the tension of the tape would accordingly remain constant. He explained that the unit was run in such a way that, as a matter of procedure, the nurses were required constantly to monitor the tension of the tapes.

On Thursday, 17 October 1991, Lee-Ann's tracheostomy tube was changed by Dr Heyns, a medical officer attached to the unit. He was assisted by staff nurse Humphries and nursing assistant Jansen. All three gave evidence and testified that they were satisfied that the tension of the tape was correct. Other nurses who cared for Lee-Ann between Thursday and Monday morning also testified that on various occasions they had monitored the tension of the tape and found

it to be adequate. The two nurses on duty in room 13 on Sunday night, that is to say from 7 pm on Sunday, 20 October, to 7 am on Monday, 21 October, were nurse Pieterse and nurse Manel. Neither observed anything untoward in the condition of Lee-Ann. The nurses' Continuous Report records that at 5.20 am nurse Pieterse cleared Lee-Ann's trachea by means of the suctioning process and also cleaned the tracheostomy site. It records also that at 6 am the suctioning procedure was repeated. This was confirmed by nurse Pieterse who said that she had found all to be well with the patient. At about 6.45 am nurse Pieterse went to see one of the matrons in the hospital about study leave she wished to take, leaving nurse Manel alone in Room 13. She testified that Lee-Ann was at that stage peaceful and clearly nothing was amiss. This was confirmed by nurse Manel. The latter testified that when the day nurses had not arrived by approximately 6.55 am she did a ward round on her own, checking the tension of each patient's tracheostomy tape.

The usual procedure was to do the round with the new nurse, but as the latter had not yet arrived, she did the round on her own. At about the same time, staff nurse Bezuidenhout and senior nursing assistant Jansen arrived at the unit. Both were scheduled to do the day shift in room 13 but because the day nurses scheduled for room 14 had not yet arrived and were late, nurse Bezuidenhout took over in room 14 and nurse Jansen took over in room 13. Nurse Bezuidenhout explained that it was not unusual for both night nurses on duty in any of the rooms to leave as soon as the first of two day nurses arrived and that it was not considered unacceptable for one nurse to hold the fort in a room until her colleague arrived shortly thereafter. Nurse Manel testified that when nurse Jansen arrived she reported to the latter that all was well and then left. Before doing so, she observed, she said, that all the patients were awake and that there were no problems. This was confirmed by nurse Jansen. She testified that she stood in the middle of the room and observed all the patients. It was then shortly before 7 am. The children were clamouring for her attention. One child in particular, Charlton, who was in the cot diagonally opposite Lee-Ann, attempted

to climb out of his cot. Nurse Jansen said she walked to the cot and lifted him up. The room was relatively small, being 7.5 by 6.5 meters and she had to take only a few steps to get to the cot. After picking up Charlton she turned around and looked back in the direction of Lee-Ann's cot. It was then that she observed that Lee-Ann's tracheostomy tube was displaced and to the left of the opening in the child's neck. She immediately put Charlton down on the floor and rushed to Lee-Ann. The latter was already limp and her colour was pale with indications of cyanosis. Nurse Jansen said she had observed no earlier signs of restlessness or distress. She said she immediately attempted to replace the tracheostomy tube. In the meantime, and while she was crossing the floor on her way to Lee-Ann's cot, she had screamed to nurse Bezuidenhout next door. This was confirmed by nurse Bezuidenhout, who testified that on hearing the scream she had immediately run into room 13. There, she observed nurse Jansen attempting to replace the tracheostomy tube. When saw Lee-Ann's colour, which she described as grey, she realised at once the gravity of the situation. Without pausing she pushed the emergency trolley towards nurse Jansen and rushed off down the corridor to summon the doctor on call. She returned with Dr Ravenscroft who took over from nurse Jansen. By this time other nurses had arrived or were arriving at the ward. Nurse Bezuidenhout estimated that it took her a minute, or even less, to return with Dr Ravenscroft. In the meantime, nurse Jansen had been unsuccessful in reinserting the tracheostomy tube. She had at first attempted to put back the tube without cutting the tape. When this proved impossible she cut the tape and tried again but still without success. She was unable to explain why she had been unable to replace the tube. Because of the mobile nature of the tissue around the neck, recannulation may involve more than simply putting the tracheostomy tube back into the surgical opening in the skin. It may also be necessary to move the tube around to find the opening in the muscle of the trachea. Where decannulation occurs within a week of the tracheostomy, recannulation can be very difficult to achieve. Once, however, the tube has been in place for a longer period, the formation of epithelial tissue results in the establishment of something in the nature of a permanent cannula

or tube so that replacement of the tracheostomy tube ought to present no difficulty. In the present case, of course, the tracheostomy had been performed more than three months previously. When Dr Ravenscroft arrived in the ward she took over from nurse Jansen and immediately, without any difficulty, replaced the tracheostomy tube and commenced the standard resuscitation procedure. At that stage there was no spontaneous breathing, no heartbeat and the patient's pupils were dilated. Something like 15-20 minutes elapsed before a spontaneous heartbeat was obtained and about 30 minutes elapsed before the patient began spontaneous breathing, that is to say without being artificially ventilated. The duration of the cerebral hypoxia was, however, such as to result in irreversible brain damage. After an initial prolonged coma, Lee-Ann passed into a permanent vegetative state from which she would never recover.

Judgment

The question was whether the failure on the part of the hospital staff promptly to replace the tracheostomy tube amounted to negligence in the circumstances. It is trite law, said Scott J, that a patient in a hospital is entitled to be treated with due and proper care and skill. The degree of care and skill that is required is that which a reasonable practitioner would ordinarily have exercised in South Africa under similar circumstances[129]. The court observed that the need for particular care and vigilance in the case of paediatric tracheostomy patients was obvious. Not only was the possibility of accidental decannulation readily foreseeable, but unless immediately remedied the consequences would be fatal. This need for care and vigilance was reflected in the staff allocated to the tracheostomy unit. The court noted that there were undoubtedly other similar units elsewhere in the world where the staff to patient ratio is higher but that a standard of excellence cannot be expected which is beyond the financial resources of the hospital authority. It accepted as reasonable a staff allocation of two nurses to each room of the unit with an overseeing sister during the day and

---

129 *Dube v Administrator, Transvaal* fn 64 *supra*

an overseeing sister shared with other wards at night. The court also said that it must be accepted that one of the two nurses in each room will from time to time be absent in some circumstances. Scott J observed that at the time of the accident there were only two nurses on duty in the unit, nurse Bezuidenhout in room 14 and nurse Jansen, in room 13. The day sister had not yet arrived and the night sister who covered the tracheostomy unit as well as the medical ward had by that time already left, after handing over to the sister in charge of the medical ward on the same floor. He pointed out that such a state of affairs was acknowledged by Dr Gie in evidence as being undesirable. The younger and higher risk patients were accommodated in room 13. Of these the youngest and the most vulnerable was Lee-Ann, hence her prime position in the room close to the nurses' desk. Scott J noted that nurse Jansen, who was left alone in room 13, was well aware of the risk of accidental decannulation and the need for vigilance and that so were the other members of staff who were prepared to walk off leaving her to hold the fort single-handed. He commented that it was also probably a bad time of day to be left alone as the patients had all recently woken up and were clamouring for attention. But this, he said, was all the more reason to keep them under careful observation. In other words, in the circumstances in which she found herself, nurse Jansen was obliged to ensure that she did not devote her attention solely to one child for too long a period. It was her duty, said Scott J, constantly to be aware of how each child was faring. Having regard to the relatively small size of the room all that would have been required was a regular glance at each child.

He observed that the impression given by nurse Jansen in her evidence was that her attention was devoted to the child attempting to climb out of its cot only for a few seconds. She said that while standing near the middle of the room where she could keep an eye on all five patients she saw the one child climbing out of its cot. She hurried to him and picked him up. She then looked back in the direction of Lee-Ann and saw that the tracheostomy tube was not in place. By that time, however, Lee-Ann was already limp. In other words, she was

unconscious. The doctors who gave evidence were agreed that on losing her tracheostomy tube Lee-Ann would in all probability have thrashed around in obvious distress or, as Dr Thomson, the paediatric neurologist, put it, she would have been fighting for her life. On the assumption that her oxygen supply was totally cut off, which would appear to have been the case, it would have taken in the region of about a minute for Lee-Ann to lose consciousness. All this, however, was missed by nurse Jansen. By the time she became aware of the problem Lee-Ann was already unconscious. She clearly devoted her sole attention to the child climbing out of his cot for a longer period than she subsequently thought. In doing so she failed, said Scott J, to exercise the care towards Lee-Ann which in all the circumstances was required of her.

The court observed that inexplicably, she was unable to replace the tracheostomy tube. She could offer no explanation for this, nor did any reason present itself. Dr Ravenscroft, when she arrived, had no difficulty. In her words, she just put the tube in. But this meant that another valuable minute was lost before ventilation could be recommenced. There can be no doubt, said the court, that the skill required of a nurse in the position of nurse Jansen, that is to say one of only two nurses present in the unit, must include the ability, in the absence of some particular problem, to replace a tracheostomy tube in an emergency. There was nothing to suggest that there was any particular problem with regard to the replacing of the tube, and in failing successfully to do so, nurse Jansen, in the judgment of the court, failed to exercise the skill expected of a reasonable nurse in her position. The court noted that situation was exacerbated by the absence in the unit of a sister or even a third nurse. It said that had the sister or another nurse been present, she could have taken over from nurse Jansen when the latter found that she could not replace the tracheostomy tube. The court held hat nurse Bezuidenhout could not be blamed. When she came into room 13 she observed nurse Jansen attending to the matter of replacing the tracheostomy tube. Lee-Ann's colour told her all. In running down the passage for help she probably did the right thing. The fact that she had to

leave the patients in room 14 unattended served, however, merely to highlight the insufficiency of the staff on duty at the time. In the view of the court, the hospital staff were negligent in failing to exercise proper care and skill in relation to Lee-Ann.

Scott J then turned to the question of damages and specifically, general damages. In this regard the plaintiff claimed in his representative capacity the sum of R200 000 for pain, suffering, shock, discomfort and loss of amenities of life. In this context, the court observed that Lee-Ann lay in what Dr Thomson described as a decerebrate posture. Her neck was extended. Her arms are extended and internally rotated with her fists clenched. She developed tremulous movements of her limbs when stimulated during examination. There was no cortical function. Her eyes were open but she was cortically blind. Her gaze was dysconjugate, i.e., her eyes were in a squinting position. She was unable to swallow and she was fed by means of a naso-gastric tube. She had no awareness of environmental stimuli, nor any apparent awareness of herself. She had no awareness of pain. She was ventilated adequately with a tracheostomy tube. She was in every respect, said the court, a 'cabbage' case.

There was some difference of opinion as to her present life expectancy. Dr Thomson thought she could live for another seven years. This view was based on his general experience and in particular on the fact that Lee-Ann had already survived for three years. Dr Gie, on the other hand, was of the view that even if Lee-Ann were to continue to receive antibiotic and other active treatment she would not survive for more than approximately another two years. In support of this view he emphasised that subsequent to the accident Lee-Ann had already experienced something in excess of 10 bouts of pneumonia and on one occasion had had to be artificially ventilated for as long a period as 14 days. He explained that all this resulted in progressive lung damage which rendered her body less able to cope with the following bout of pneumonia and that it was inevitable that she would die of pulmonary disease. The court preferred Dr Gie's opinion

due to his having a special interest in paediatric pulmonology, and his being the person with particular knowledge of Lee-Ann's clinical history. Both doctors agreed that Lee-Ann would remain in a permanent vegetative state until she died and that the latter event would probably occur within a matter of a few years.

It followed, said the court that it was of no consequence to Lee-Ann what amount, if any, was awarded to her in respect of non-pecuniary damages. Not only would she never know of the award, she would receive no benefit from it whether knowingly or unknowingly. As counsel for the defendant poignantly put it, 'one cannot even buy her a teddy bear'. Scott J stated that there was something unreal in attempting to compensate her. He said it was like trying to compensate a dead person with money. He observed that had she not been resuscitated and had she died, her claim for non-pecuniary damages would have died with her. It would not have passed to her estate[130]. In truth, said Scott J, she was more dead than alive. Her body continued to function, but her mind was gone. Her parents seldom visited her. Their failure to do otherwise, he said, was understandable. There was nothing to visit. He noted that Lee-Ann merely existed, lying in hospital waiting for her tenuous link with this world to be finally severed. Counsel for the defendant, submitted that as no award of non-pecuniary damages would serve any purpose, it would be proper in all the circumstances for no award to be made under this head.

Scott J observed that the problem of how to compensate persons in such a condition, frequently referred to in the cases as the 'unconscious' plaintiff, has been the subject of much debate and difference of judicial opinion. The question was considered in England by the Court of Appeal in *Wise v Kaye and Another*[131] and by the House of Lords in the two subsequent decisions of *West &*

---

130 *Hoffa NO v SA Mutual Fire & General Insurance Co Ltd* fn 62 *supra*

131 *Wise* [1962] 1 All ER 257 (CA)

Son Ltd and Another v Shephard[132]and *Lim Poh Choo v Camden and Islington Area Health Authority*[133]. Scott J summed up as follows the position in England as reflected in these cases as far as non-pecuniary damages are concerned, i.e. damages for pain and suffering and loss of amenities of life. Since an unconscious person is spared pain and suffering, he or she will not qualify for damages under this head. Similarly, because he or she is spared the anguish which may result from the knowledge of what in life has been lost or from the knowledge that life has been shortened, he or she will also not be entitled to damages in respect of this subjective element of the loss of amenities of life. But the fact of unconsciousness does not eliminate the actuality of the deprivation of the ordinary amenities of life and for this objective element of the loss, he or she is entitled to substantive damages. Scott J stated that the approach to the question of pain and suffering and the subjective element of the loss of amenities of life presented no difficulty. Since an unconscious plaintiff suffers no pain and has no feelings there is ipso facto no 'loss' to be compensated. He pointed out that this approach is consistent with that adopted in *Sigournay v Gillbanks*[134].

The difficulty, said Scott J, lies with the so-called objective element of the loss. He noted that it is inherent in the speech of Lord Scarman in the *Lim Poh Choo* case and in the majority speeches in the *H West & Son* case that the award of non-pecuniary damages in respect of the actuality of the loss is to be determined without regard to the fact of the plaintiff's unconsciousness and without regard to the use to which the money so awarded may thereafter be put. It was, furthermore, fundamental to the approach adopted in the majority speeches that it was the objective element of the loss which was the greater, and not the subjective element, so that the award for the actuality of the deprivation of amenities of life must be substantial, notwithstanding the unconsciousness of

---

132 *West* [1963] 2 All ER 625 (HL)
133 *Lim Poh Choo* [1979] 2 All ER 910 (HL)
134 *Sigournay* 1960 (2) SA 552 (A)

the plaintiff. The court observed that the conclusion in the three English cases has not been without dissent and that Lord Scarman in the *Lim Poh Choo* case spoke of the 'formidable logic and good sense of the minority opinions expressed in *Wise v Kaye* and *H West & Son Ltd v Shephard*', and of Lord Denning's 'powerful dissent' in the Court of Appeal in the *Lim Poh Choo* case.

Scott J noted that a complicating factor has been the position in England with regard to the claim for loss of expectation of life. Such a claim is by statute transmissible to the deceased's estate so that it is possible for damages to be awarded against a tortfeasor where the victim could not enjoy the proceeds of the judgment. Prior to 1941 the measure of damages to be awarded in such cases was so vague that in practice this head of damage got out of hand. In that year the House of Lords in *Benham v Gambling*[135] decided that the damages in such cases had to be diminished and that only very moderate amounts would be allowable. Viscount Simon LC referred to the extreme difficulty in putting a money value on a prospective balance of future happiness and ultimately awarded a nominal sum of £400. In the *H West & Son* case both Lord Reid and Lord Devlin in their dissenting speeches referred to *Benham v Gambling* and relied on this case, at least partly, to justify their conclusion that far greater weight should be attached to the subjective element of the loss rather than the objective element, so that in the case of an unconscious plaintiff only a moderate figure should be awarded in respect of his objective loss of amenities of life. A similar approach was adopted by Diplock LJ in his dissenting judgment in *Wise v Kaye* and by at least three Judges in the Australian High Court case of *Skelton v Collins*[136]. A fact which was also of concern to Lord Reid and to Lord Devlin was the inability of the plaintiff to derive any benefit from the award, although neither considered this to be a decisive consideration.

---

135 *Benham* [1941] 1 All ER 7 (HL)
136 *Skelton* (1966) 115 CLR 94

The court observed that there were only two reported cases involving the compensation of an unconscious plaintiff in South African law. The first, *Gerke NO v Parity Insurance Co Ltd*[137], was a case of a 21-year-old man who had been rendered permanently unconscious in a motor accident. His condition was described as 'vegetative' and he was expected to live for only another six months. In his judgment, Ludorf J referred to *Wise v Kaye and Another* (*supra*) and quoted at length from *H E West & Son Ltd and Another v Shephard* (*supra*). After confessing that he had been influenced by the reasoning of the Law Lords in the latter case, the Judge disposed of the problem of the plaintiff's unconsciousness on the simple basis that, as unawareness was not a disqualification for a claim for loss of earnings, it should not be a disqualification for a claim for loss of amenities of life as the latter claim 'has been classified with a claim for patrimonial loss'. Scott J stated that he did not think that it followed at all that, simply because awareness is not a requirement for a claim for loss of earnings, it should also not be required for a claim for loss of amenities of life. He said that although the former has its own peculiar problems in relation to an unconscious plaintiff, the claim is one which is of a pecuniary nature and is accordingly very different from the latter which is non-pecuniary. He stated that the fact that the latter may have been 'classified' in a particular way can surely not change its true nature. This aspect of the case has been severely criticised.[138]

With regard to the award in respect of loss of expectation of life, Scott J observed that the suffering and anguish experienced by a conscious plaintiff will ordinarily be increased by the prospect of a premature death. Where, however, the plaintiff is unconscious, he is unaware of this. He is spared both pain and the anguish of knowing that his life has been cut short and therefore has no claim for this subjective element of the loss. He notes that this is self-evident and is the position both in England and Australia. In the *Gerke* case the plaintiff was unconscious and the award must therefore, said Scott J, have been founded upon

---

137 *Gerke* 1966 (3) SA 484 (W)

138 For a summary of some of the criticisms levelled at this judgment see Boberg (fn 28 *supra*) at p 567-9.

the objective fact of the loss of expectation of life. He pointed out that the award on this basis has its roots in the English statutory provision in terms of which a claim for loss of expectation of life is transmissible. In South Africa, a claim for loss of expectation of life, like the claim for pain and suffering, is not transmissible to the claimant's heirs. Scott J was of the view that there appears to be no justification for the importation from England of this 'rather special head of damages'.

In support of the award under this head, Ludorf J in *Gerke* also referred to *Goldie v City Council of Johannesburg*[139] and *Dickinson v Galante*[140]. Scott J said that it appears from the passages quoted that in the former case counsel for the plaintiff disavowed any specific claim for shortened expectation of life along the lines of that accepted in *Benham v Gambling* (*supra*), and in the latter case Thomas J rejected the notion of a claim for diminished expectation of life *per se*. In the third case cited, *Roberts NO v Northern Assurance Co Ltd*[141], Scott J notes that Burne J appears to have accepted the existence of a claim for the objective loss of life expectation on the basis of what was said by Lord Morris in the H West & Son case without further ado[142]. The other aspect of the award in *Gerke* upon which Scott J commented was that Ludorf J appears to have accepted the minority view in the *H West & Son* without alluding to that fact.

Scott J stated that the majority view in the H West & Son case was that it is the objective element of the loss which is the greater and not the subjective element. The other reported case to which the court was referred involving the claim of an unconscious plaintiff for non-pecuniary damages was *Reyneke v Mutual & Federal Insurance Co Ltd*[143]. This case concerned a 16-year-old girl who was

---

139 *Goldie* 1948 (2) SA 913 (W)
140 *Dickinson* 1949 (3) SA 1034 (SR)
141 *Roberts* 1964 (4) SA 531 (D)
142 Luntz H'Damages in cases of Brain Injury - Some Developments' (1967) 84 *SALJ* at p 6 also criticises the decision in *Gerke*
143 *Reyneke* 1991 (3) SA 412 (W)

left in a persistent vegetative state after being knocked down by a motor car. At the time of the trial her life expectancy was estimated at 7.5 years and it was accepted that she would not recover consciousness. On the strength of the English cases, Claasen AJ drew a distinction between the subjective element of the loss, that is to say, pain, suffering, mental anguish, fear, anxiety, etc, on the one hand, and on the other, the objective element of the loss, that is to say, loss of amenities of life, reduced expectation of life, disfigurement etc. As far as the latter element is concerned, he felt that in view of the decision in *Southern Insurance Association Ltd v Bailey NO*[144] some allowance had to be made for the unlikelihood of the claimant being able to make use of any amount so awarded and to this extent departed from the decision in *H West & Son v Shephard* in which it was held by the majority that the use to which any award could be put was irrelevant. Claasen AJ concluded that subject to such an allowance an award had to be made in respect of the objective element of the loss (and also the subjective element, notwithstanding the claimant's unconsciousness) and awarded an amount of no less than R50 000 for the objective element of the loss. He then disposed of the problem of compensating an unconscious patient with an award of non-pecuniary damages in a single paragraph stating that:

'The principal criticism levelled at awarding damages to a "cabbage" for pain and suffering and loss of amenities of life is that money is paid for enjoyment of life to a person who does not know that he had suffered such loss of enjoyment. It is said one is consoling someone with money who does not know that he needs consolation and it is said that consolation presupposes consciousness and some capacity of intellectual appreciation. In my view the fallacy in this argument is that it equates a dead man with an unconscious man. It also implies that it is "cheaper to kill a man than to maim him".'

Scott J said he had difficulty in appreciating the fallacy to which he refers and argued as follows. An unconscious person is as inconsolable as a dead person and to this extent there is a similarity between the two. Indeed this is the objection to awarding non-pecuniary damages to a permanently unconscious

144 *Bailey* 1984 (1) SA 98 (A)

person. It is no different from awarding damages to a dead person. As far as it being cheaper to kill a man than to maim him, this is undoubtedly so in the absence of a dependant's claim. But the reason is that the action is compensatory and not punitive. Scott J noted that a further justification for the award relied upon by Claasen AJ was that the unconscious plaintiff 'has a right to be visited by her family while still alive' and that an award of general damages could be used to pay the transport costs of her family and friends. Claasen AJ considered that 'in such instances the money is in fact employed to console her and to alleviate her lot in life, however small'. He felt, accordingly, that 'the defendant could not be heard to say "Suzette is not aware of the presence of her family and friends and therefore I should not be forced to pay any contribution towards the costs of having them at her bedside".' Scott J agreed that an award of non-pecuniary damages could be used by a conscious plaintiff to have her family and friends visit her and in this way the award would provide some consolation for her loss. The use of the award in this manner could therefore be a factor to which a court may have regard when considering the quantum of non-pecuniary damages to be awarded.[145] But, said Scott J, where the plaintiff is unconscious, neither the award nor the visit can provide any consolation and the award accordingly serves no purpose. He thus refused to agree with the reasoning of Claasen AJ. He said that there may be a pecuniary claim for such transport costs, but no such claim was made in the present case and it is unnecessary to consider the matter. Scott J noted that Claasen AJ awarded the sum of R10 000 in respect of reduced life expectancy and stated that for the reasons given when considering the *Gerke* case, he considered this award to have been unjustified.

Scott J identified two principal objections to what is essentially the English approach, involving a notional distinction between a subjective and objective element of the loss of amenities of life and the award of non-pecuniary damages in respect of the objective loss or the actuality of the loss. He stated that there

---

145 *Marine & Trade Insurance Co Ltd v Katz NO* 1979 (4) SA 961 (A) at p 983B-E

would appear to be unanimity that an unconscious person is not entitled to damages for pain and suffering or anguish, that is to say the subjective element of the loss of amenities, since he or she suffers no pain and experiences no anguish and that the objections to the English approach are the following -

- First, the award of non-pecuniary damages in respect of the actuality of the loss serves no purpose as the money awarded cannot be used for the benefit of the unconscious plaintiff.
- Second, it can provide no consolation to an unconscious plaintiff, as consolation presupposes consciousness and some capacity of intellectual appreciation. A conscious person who, by reason of his injuries, is incapable of deriving any advantage from a monetary award can notionally obtain some consolation from the receipt of money and from being able, if he pleases, to give it away. An unconscious person cannot even have this consolation.

Scott J noted that the so-called 'functional' approach involves the award of non-pecuniary damages only to the extent that such damages can fulfil a useful function in making up for what has been lost in the sense of providing for physical arrangements which can make the victim's life more endurable. He observed that in *Southern Insurance Association Ltd v Bailey NO* it was argued on behalf of the appellant (the defendant) that the functional approach should be adopted in South Africa. Nicholas JA, who delivered the judgment of the Court, referred to the *Lim Poh Choo* case and noted that in England the functional approach had been rejected by the highest Court, but, after a brief review of various dicta in South African cases, stated:

'This Court has never attempted to lay down rules as to the way in which the problem of an award of general damages should be approached. The accepted approach is the flexible one described in the often quoted statement of Watermeyer JA in *Sandler v Wholesale Coal Suppliers Ltd* 1941 AD 194 at 199: "The amount to be awarded as compensation can only be determined by the broadest general considerations and the figure arrived at must necessarily be uncertain, depending upon the Judge's view of what is fair in all the circumstances of the case."
I do not think that we should now adopt a different approach. To do so might result in injustice of the kind referred to in Lord Scarman's speech in the *Lim Poh Choo* case.

This does not mean, of course, that the function to be served by an award of damages should be excluded from consideration. That is something which may be taken into account together with all the other circumstances.'

Scott J said that it was apparent from the ultimate paragraph of this passage that the Appellate Division has taken a view which is different from that adopted in the *Lim Poh Choo* case. The approach in England to the question of the unconscious plaintiff as confirmed in the *Lim Poh Choo* case involves disregarding entirely the use to which non-pecuniary damages may be put. Once, however, it is accepted that the function to be served by an award of damages is a relevant consideration it is difficult to see how the English approach can be followed, even in a modified form. The objection to the English approach to compensating an unconscious plaintiff is not merely that the amount awarded will not serve a useful purpose in ameliorating the loss, which is the aim of the functional approach. The objection is that it will not serve any purpose at all, whether useful or otherwise. In the *Reyneke* case Claasen AJ thought the solution was a 'paring down' of the damages to take into account the fact that the plaintiff is unable to derive any benefit from the award.

But the problem, said Scott J, is a paring down to what? Whatever the amount awarded, it will have no relevance whatsoever to the person whom it is sought to compensate. Where, as a result of injury, a plaintiff is mentally retarded even to the extent that he may have no insight into his loss, provided only that he has awareness, an award of non-pecuniary damages can be utilised for his benefit even if the expenditure is frivolous and does no more than amuse him. Where the plaintiff is unconscious and all his physical needs have been taken care of, the truth of the matter is that it is not possible to compensate him for his loss. He said it is like paying a dead person money in order to compensate him for the loss of his life. It is true that, if no award of non-pecuniary damages were to be made on account of the unconsciousness of the victim, it would mean that the wrongdoer would benefit. But the simple answer is, of course, that the action is

not punitive, it is compensatory. There is accordingly no basis in our law for an approach such as that adopted in Germany where a nominal award, it would seem, is made to reflect society's demand that some retribution be made for the injustice done to the plaintiff. The same is true of Professor Boberg's suggestion that the courts continue to award a 'nucleus of damages for loss of amenities of life to the unconscious plaintiff a la Gerke' so as to enable 'the law to express society's sympathy with the victim and its sense of outrage at his grievous loss' or the solution offered by Visser and Potgieter Law of Damages at 96, that the award serve as a 'symbolic reparation of the damage' and 'to effect retribution for the injustice, and to soothe the community'. To adopt such a 'solution' would be to import into our modern delictual action a penal element for which, in the view of Scott J there is no justification[146].

In asking whether a departure from the English approach is justified, Scott J stated that it is difficult in the first place to resist the conclusion that the English approach and, indeed, the distinction between the subjective and the objective element of the loss of amenities of life owes its existence to the Law Reform (Miscellaneous Provisions) Act, 1934, in terms of which a claim for loss of expectation of life was rendered transmissible. He states that because of this the need arose to place a value on the loss viewed objectively and it would seem that the distinction between the subjective and objective element of the loss was then simply applied to the case of the unconscious plaintiff. But in South Africa a claim for loss of expectation of life is not transmissible and the need for the distinction does not arise. Nor, says Scott J, is there any logic to it unless the claim in respect of the objective element is, or ought to be, transmissible, because in the end it is only the heirs of the unconscious plaintiff who get the benefit. He noted that the position in England is hardly satisfactory, that there has been a remarkable difference of judicial opinion on the subject and that the need for review would seem to be acknowledged. Scott J stated that he saw no

---

146 The court also referred to Van der Merwe and Olivier *Die Onregmatige Daad in die Suid-Afrikaanse Reg* 6th ed at 195 where the learned authors point out that in our modern law of delict there is no room for penal damages.

reason to blindly follow the English law approach. He said that the persons who will really be prejudiced if an award of non-pecuniary damages is not made are Lee-Ann's parents, the plaintiff and his wife. He said that he had much sympathy for them. The accident and its consequences must have caused them much grief and sorrow but they do not claim damages for their grief and inevitable bereavement. Nor, said Scott J, as a matter of policy, could such a claim ever be entertained because the social burden would be too great. He observed that free medical treatment had recently been afforded in South Africa to all children under the age of six years and that all this costs money. The same is true, said Scott J, in the case of other public bodies which are defendants in actions arising out of bodily injuries.

Scott J acknowledged that his decision would constitute a radical departure from the decisions in *Gerke* and *Reyneke*. He said that there are also, no doubt, other unreported cases in which damages have been awarded in similar circumstances. Nonetheless, said Scott J, there was no great body of precedent which, in his view, would justify the perpetuation of an award of damages which he regarded as being contrary to principle and the law. Finally, he considered the question of whether the decision in Bailey's case not to embrace the functional approach obliged him to make an award of non-pecuniary damages in the present case. He concluded that it did not saying that the functional approach involves limiting an award to an amount which can serve a useful purpose. In the circumstances of the present case, Scott J argued that an award would not only serve no useful purpose, it would serve no purpose at all, whether useful or otherwise. The claimant, by reason of her condition, is in truth, incapable of being compensated by a monetary award. In the *Bailey* case, said Scott J, the court was not concerned with the case of an unconscious plaintiff and was accordingly dealing with a very different situation.

Discussion

This decision is controversial in the sense that there is a feeling that the award in damages does not sufficiently recognise or acknowledge the extent of the loss sustained. Whilst the logic that damages awarded in terms of the law of delict are compensatory and that therefore the extent to which the plaintiff is able to experience the loss must be taken into account is perfectly understandable there is somehow an absence of satisfaction that justice has been done. Possibly the problem is that this approach is too utilitarian[147]. Its basis in cold hard logic does not accord with the general sense of the value of human life and the fact that if one cannot exercise the right to life none of the other rights have any meaning. Although it could be argued that biologically those in a persistent vegetative state are still alive in medical and legal terms, the court in *Clarke v Hurst*[148] argued convincingly that for all other purposes they are not. The question then

---

147 Hurley S 'Distributive Justice and Health' *Fairness and Goodness: Ethical Dimensions Of Health Resource Allocation* expresses the matter in a slightly different context thus: "We begin with the 'what' question. One view is that distributive justice is ultimately concerned with welfare. It's an attractive thought that each person's welfare matters just as much as any other's, the peasant's as much as the aristocrat's. There should be no favoritism: we should not treat a given benefit to one person as more important than an equal or greater benefit to another. This thought is one of the motivations for utilitarianism. According to utilitarianism, you should allocate each unit of resource to the person who will get the most welfare from it. To allocate a unit of resource to someone who will get less additional welfare from it than someone else would have got from it is to treat the former's welfare as more important than the latter's. The effect of allocating each unit of resource to the person who gets the most welfare from it is to maximize total welfare. In this way the no-favoritism ideal can motivate the position that aims to maximize welfare. However, this way of thinking has unattractive implications concerning some unhealthy or disabled persons. Consider someone who is blind and, in order to be mobile, maintains a seeing-eye dog. Or someone who needs regular dialysis. It seems that many such persons would get less welfare from any given allocation of income than would someone bursting with health. A substantial part of a resource allocation to an unwell or disabled person may have to be spent just raising her to a minimal level of welfare, one which healthy persons take for granted: in paying for food for the seeing-eye dog or for dialysis for example. There are of course many other possible answers to both the 'what' and the 'how' questions, and other possible views about justice, such as libertarian views and views that urge the maximization of welfare or of resources, which are not included in this schema.... It seems that, in most cases at least, health generates welfare out of resources more efficiently than lack of health. But utilitarianism treats health conditions, along with other conditions, as merely the means to more or less welfare. This means that the utilitarian, who aims to allocate each unit of resource where it will produce the most welfare, will direct resources away from the unhealthy and disabled in favor of the healthy, to the extent the healthy are more efficient generators of welfare. As a result, the unhealthy and disabled will be left with lower total levels of resources, and lower total levels of welfare, than the healthy. This result conflicts with the intuitions many people have about just resource allocations. If the welfare benefits in question are very small, or if a much greater welfare benefit could be provided to the healthy than to the unwell, many people do favor allocations that benefit the healthy and maximize welfare. However, where substantial benefits are in question and equal welfare benefits could be provided to healthy and the unwell, many think we should allocate resources to the unwell. Moreover, they would favor the unwell even if a somewhat greater welfare benefit could be provided to the better off (Daniels and Sabin 1997, 320). Allocations that increase the welfare of the unwell or disabled are in some cases regarded as more important or more urgent than allocations that increase the welfare of the healthy, even if the former do not maximize welfare."
Acocella N in 'Theories of Justice: Social Conditioning and Personal Responsibility in Roemer's Contribution' (http://host.uniroma3.it/progetti/csei/communicazioni/justice.pdf) points out that: "Theories of justice differ essentially because of different visions, i.e., the intertwining of value judgments and analytic elements concerning the way human 'systems' work (from and economic, social, psychological and biological point of view). Differences in the system of value judgments are thus one of the two causes of divergences in theories of justice."

148 *Clarke v Hurst* 1992 (4) SA 630 (D)

is whether the approach of Scott J in *Collins* saying that attempting to compensate a person in a persistent vegetative state is like trying to compensate a dead person, accords with public policy and perceptions of justice. The problem seems to be that if one extends the logic in the abstract, one is faced with a situation in which damages or compensation should be commensurate with the capacity of the plaintiff to experience loss, the subjective awareness of the plaintiff of extent of that loss, as opposed to the value placed by society as a whole on that which is lost. In the context of the law of delict, one runs into problems here with the fact that the concept of wrongfulness is based on the legal convictions of the community and that once an act or omission has been found to be wrongful, there should be a measure of compensation which satisfies society's rather than the plaintiff's sense of justice. Of course wrongfulness is only one element of the law of delict and the other elements are not all necessarily dependent on the legal convictions of society for their content.

One gets into all kinds of ethically and legally tricky situations in entering a logical arena in which compensation is dependent upon the ability of the plaintiff to comprehend and experience the loss. Take the example of a man who has injured his hand in an industrial accident. Assume that such claims are still settled in terms of the law of delict and not under workmen's compensation law. The hand had to be partially amputated with the result that he is now left with a very unsightly, badly scarred, but still relatively functional 'claw' in which he still has the use of a thumb and two fingers. This man is inordinately conscious of his personal appearance and is profoundly psychologically affected by the partial loss of his hand. He feels he would rather have it amputated and replaced by a prosthesis which although it may be less functional than what he has now, would be more aesthetically pleasing to him and easier to live with psychologically. He approaches a doctor with the request that the remainder of his hand is amputated. How should the doctor respond? Should his decision be based on the view of society that it would be wrong to amputate the hand

because it is more functional than a prosthesis would be and that the amputation is technically medically unnecessary or should he accede to the patient's wishes on the basis that the latter values a prosthesis more highly than his semi-amputated hand? If one uses the logic that this man's awareness of the partial loss of his hand is more acute than that of most men, must he then receive a greater award in damages than would ordinarily be granted or does this principle of subjective consciousness of loss operate in only one direction – to decrease the quantum of damages that should be awarded to the patient?

Take another example of two people, both final year medical students with similar future prospects, who consent to a clinical trial for a new drug. One of them was once blind for a number of years when he was younger before an operation restored his sight. The other has enjoyed normal sight throughout his life. In the course of the trial they both go blind as a result of the negligent and wrongful actions of the researchers . Could it be argued that -

(a) Because the one knew what it was like to blind some years ago, and is better adapted to living without his sight, the extent of his loss is not as great as that of the other who has to adapt to a totally new set of circumstances?
(b) Because one did not know what it was like to be blind, his consent to the trial was less meaningful and not as informed as that of the one who knew what it was to be blind even though the consent procedure that was followed was the same for both of them?
(c) Because the one had already been blind previously and subsequently had it restored, his sight was more valuable to him than that of the one who had never been blind and so his loss was greater?
(d) The extent of the damages payable to them should be the same based on the value that is generally placed by society on the ability of a medical doctor to see?

Scott J's approach to distributive justice in the case of *Collins* is distinctly utilitarian in the sense that the resources must remain where they are most

useful. There is no point in transferring resources to a person who has no need of or use for, them. In the context of *Collins*, it is a highly persuasive argument in a country where health care services in the public sector are significantly under-resourced. In terms of traditional legal reasoning, it is not the calculation of damages that is influenced by public policy – only the element of wrongfulness[149]. Even in cases where wrongfulness is proven, this on its own is

---

149 In fact the argument that there are no public policy considerations applicable in assessing the quantum of damages is not correct. The element of legal causation for the purpose of limiting the extent of the damages for which a defendant is liable is also very much dependent on public policy considerations. With regard to the purely compensatory nature of damages in delict, see the dicta of Scott J in *Zysset and Others v Santam* 1996 (1) SA 273 (C) where he states: "The modern South African delictual action for damages arising from bodily injury negligently caused is compensatory and not penal. As far as the plaintiff's patrimonial loss is concerned, the liability of the defendant is no more than to make good the difference between the value of the plaintiff's estate after the commission of the delict and the value it would have had if the delict had not been committed. See *Dippenaar v Shield Insurance Co Ltd* 1979 (2) SA 904 (A) at 917B. Similarly, and notwithstanding the problem of placing a monetary value on a non-patrimonial loss, the object in awarding general damages for pain and suffering and loss of amenities of life is to compensate the plaintiff for his loss. It is not uncommon, however, for a plaintiff by reason of his injuries to receive from a third party some monetary or compensatory benefit to which he would not otherwise have been entitled. Logically and because of the compensatory nature of the action, any advantage or benefit by which the plaintiff's loss is reduced should result in a corresponding reduction in the damages awarded to him. Failure to deduct such a benefit would result in the plaintiff recovering double compensation which, of course, is inconsistent with the fundamental nature of the action. Notwithstanding the aforegoing, it is well established in our law that certain benefits which a plaintiff may receive are to be left out of account as being completely collateral. The classic examples are (a) benefits received by the plaintiff under ordinary contracts of insurance for which he has paid the premiums and (b) moneys and other benefits received by a plaintiff from the benevolence of third parties motivated by sympathy. It is said that the law baulks at allowing the wrongdoer to benefit from the plaintiff's own prudence in insuring himself or from a third party's benevolence or compassion in coming to the assistance of the plaintiff. Nor, it would seem, are these the only benefits which are to be treated as *res inter alios actae*. In *Mutual and Federal Insurance Co Ltd v Swanepoel* 1988 (2) SA 1 (A) it was held, for example, that a military pension which was in the nature of a solatium for the plaintiff's non-patrimonial loss was not to be deducted. Nonetheless, as pointed out by Lord Bridge in *Hodgson v Trapp and Another* [1988] 3 All ER 870 (HL) at 874a, the benefits which have to be left out of account, 'though not always precisely defined and delineated', are exceptions to the fundamental rule and 'are only to be admitted on grounds which clearly justify their treatment as such'. It is submitted this baulking of the law to which Scoitt J refers is based on none other than consideration of public policy. In fact Scott confirms this subsequently in the judgment when he goes on to observe: "It is doubtful whether the distinction between a benefit which is deductible and one which is not can be justified on the basis of a single jurisprudential principle. In the past the distinction has been determined by adopting essentially a casuistic approach and it is this that has resulted in a number of apparently conflicting decisions. Professor Boberg in his *Law of Delict* vol 1 at 479 explains the difficulty thus: '(W)here the rule itself is without logical foundation, it cannot be J expected of logic to circumscribe its ambit.'
But, whatever the true rationale may be, if indeed there is one, it would seem clear that the inquiry must inevitably involve to some extent, at least, considerations of public policy, reasonableness and justice (see *Santam Versekeringsmaatskappy Bpk v Byleveldt* 1973 (2) SA 146 (A) at 150E-F and 153B-C; see also Neethling, Potgieter and Visser *The Law of Delict* 2nd ed at 221-2). This in turn must necessarily involve, I think, a weighing up of mainly two conflicting considerations in the light of what is considered to be fair and just in all the circumstances of the case. The one is that a plaintiff should not receive double compensation. The other is that the wrongdoer or his insurer ought not to be relieved of liability on account of some fortuitous event such as the generosity of a third party.
Another case which clearly demonstrates the relevance of public policy considerations to the quantum of damages is *Jones v Krok* 1996 (1) SA 504 (T). In that case Kirk-Cohen J stated obiter that: It is the policy of South African law and practice that for breach of contract the injured party is entitled to no more than compensation for the damages actually suffered by him. The quantum is not in any way dependent upon, or influenced by, the reprehensible behaviour of the defendant or the flagrancy of the breach (*Administrator, Natal v Edouard* 1990 (3) SA 581 (A)). The same applies to the assessment of the quantum of damages under the lex Aquilia: see *Santam Versekeringsmaatskappy Bpk v Byleveldt* 1973 (2) SA 146 (A) 152H. It is thus trite that the award of punitive damages in such instances, in which category falls the award in this case, is alien to our legal system The mere fact that awards are made on a basis not recognised in this country does not entail that they are necessarily contrary to public policy. Whether a judgment is contrary to public policy depends largely upon the facts of each case.... In principle it would be wrong to refuse to enforce a foreign order of punitive damages

insufficient to succeed in a claim in delict. The object of pursuing such a claim is compensation for the loss suffered. Therefore the nature and extent of that loss, i.e. damages must be proven. Where the loss is so great that no amount in damages will constitute satisfactory compensation, the utilitarian approach is that no award of compensation can be made.

In discussing the concept of justice in relation to health Kolm[150] notes fairness about health gives rise to innumerable considerations in the field of health care. At a more global level, he says, there is a tradition of concern about fairness and health induced by the correlations between health and socio-economic status. He notes that the field of conceptual justice is neither the application of a simplistic universal principle (or bundle of a few principles), nor an amorphous heap of *ad hoc* criteria found and applied according to intuition. It is a structured, rational, deductive construct starting from necessary concepts, properties and distinctions and unfolding to applications. A basic issue is whether justice about a particular good, such as health, makes sense, or whether justice should be considered globally. Kolm makes the point that concerning health, the answer is both ambivalent and special because of the particular importance it can have.

If one applies utilitarianism to one aspect of justice as applicable within the ambit of the law of delict then this same principle should be extent to other

---

merely because it is unknown in this country. In my view it cannot be said that the principle involved is necessarily unconscionable or excessive or exorbitant." Provisional sentence was refused on the grounds that (a) while the appeal was still pending in the US Court of Appeal, the judgment of the US Court was not a final one; (b) the award of punitive damages was contrary to public policy and a foreign order for such damages would not be enforced by South African Courts; and (c) the award of compensatory damages rested 'upon the same foundation' as the award of punitive damages and would thus not be enforced. In *Jones v Krok* 1995 (1) SA 677 (A) the Appellate Division reversed the decision of Kirk-Cohen J holding *inter alia* with regard to the Court a quo's refusal of provisional sentence on the grounds that the award of 'compensatory' damages by the foreign Court had been 'arbitrary' and that it would be contrary to public policy to enforce it, the Court held that there had been no valid basis for such findings and, in any event, that such findings seemed to have involved entering into the merits of the case adjudicated upon by the US Court, which was not permissible. It concluded that public policy afforded no ground for denying the appellant relief in respect of the amount of US$13 670 987. Although Kirk-Cohen J concluded that the punitive award of damages would not be enforced the *obiter dicta* in this judgment indicate that there may be circumstances in which damages that are not purely compensatory could be recognised. This view seems to have been supported by the Appellate Division in reversing the decision of Kirk-Cohen J. See also in this regard the discussion of *Mukheiber v Raath* in chapter 9.

150 Kolm SC 'On Health and Justice' Institute for Advanced Studies in the Social Sciences, Paris ftp://194.167.156.192/EE/kolm4.pdf

practical mechanisms for the achievement of justice in other areas of law. In health care the utilitarian approach is particularly problematic and is not generally supportive of constitutional values[151]. Why should one not allow poor people to sell their organs if it this will improve their lives? Why should they not be able to sell blood and gametes? After all these things are a resource which they possess and upon which others place value. Why should unemployed people who contribute nothing to the economy who have AIDS be treated with expensive antiretroviral drugs if it is cheaper simply to let them die? Of what value to society are their lives? By prolonging their lives one is simply giving them greater opportunity to create AIDS orphans who will become a growing and unnecessary burden on already overstretched state resources. Are such lives of any greater value to society than the life of the baby in *Collins*?

On the other hand, the argument that the criminal law exists to punish people is a valid one. The argument that the standard of proof in criminal law should not be undermined by allowing punitive measures to be imposed *via* the back door of the law of delict which imposes a lower standard of proof is also valid.

---

151 Hurley S, fn 147 *supra* points out that utilitarianism requires the allocation of each unit of resources to the person who will get the most welfare from it but that this way of thinking has unattractive implications for unhealthy or disabled persons. Utilitarianism, she says, treats health conditions, along with other conditions as the means to more or less welfare. She states that one prominent answer draws a fundamental distinction between welfare and resources and claims that what justice requires us to equalize is resources, not welfare. Welfare is a matter of the satisfaction of an individual's preferences and ambitions. These are down to the person herself and do not make a call on justice. The difference between someone whose preferences and ambitions are well adapted to his disability and someone whose preferences and ambitions are not so adapted to his similar disability does not make it just to compensate only the poorly adapted person. Each person should be treated as responsible for his preferences and ambitions as free to make what he will from his circumstances against a background of fair equality and resources. Resources, by contrast, are a matter if someone's endowments and the circumstances she finds herself in. Someone born into a rich and prominent family or highly gifted has to that extent valuable endowments which someone born into poor and obscure circumstances, or without special gifts, lacks. The former person has on this account greater resources than the latter. Similarly someone born with normal vision and good health has a valuable endowment and to that extent has greater resources than someone born blind or susceptible to major health problems. Such endowments are like different internal circumstances people find themselves in. They are not down to the people themselves in the way their different preferences and ambitions are. Ronald Dworkin, she says, distinguishes inequalities of welfare that result from people's different preferences or tastes or ambitions from inequalities in resources, differences in circumstances or endowments. He conceives justice as requiring equality of resources but not equality of welfare. For example, to have expensive tastes is to have a welfare deficit relative to someone with less expensive tastes, other things equal Nevertheless, someone's expensive tastes are down to him and do not in themselves make a call on justice. Similarly if people who have the same endowments have different preferences and ambitions and accordingly make different choices in life that lead to their being better or worse off, the Dworkian aim to equalise resources will leave such inequalities alone. Some people may choose to work hard and get rich whole others take lots of leisure and don't get rich. Some may assiduously avoid risks and insure heavily against risk, while others may blithely run risks and fail to insure. To the extent the resulting differences reflect differing preferences and ambitions, they are not unjust.

However, not every wrongdoing is prosecuted for any number of reasons, not every criminal is convicted, and not every victim receives justice in the criminal justice system. In fact in terms of constructive justice the criminal legal system seems to offer relatively little. It takes people out of circulation and marginalizes them in the eyes of society and in their own eyes. With regard to deterrent value, it can be argued that there is no deterrent value in claims pursued in terms of the law of delict - that this deterrent value is located rather within the criminal law. In response, it is submitted that it is not the role only of the criminal law to uphold, maintain and enliven the values and principles of the Constitution and that justice in the form of 'reparation' rather than mere compensation is an avenue that is worth exploring in the particular context of the civil law and the situation in *Collins*. There are those who would observe that in South Africa the criminal law serves only as a deterrent to those who are not criminally inclined to begin with since there seems to be little or no deterrent value for the criminally inclined in the threat of criminal prosecution and sanction given the high levels of extremely violent and brutal crime that plague this country.

It is submitted that the foregoing discussion indicates that mere logic is not always sufficient to arrive at legal answers which are acceptable to the community served by a particular legal system. Law is a combination of interwoven values and logical constructs that does not constitute an end in itself but is rather a vehicle for realizing the social, humanitarian, economic, political and other goals of the society that effects it. Where many people feel a deep sense of unease with a judgment such as that in *Collins v Administrator Cape*, it is important to explore and understand the reasons why. At the end of such exploration, one might concede that the conclusion was correct although it seems counter-intuitive until a closer examination is made of the issues involved. It may be that public policy dictates that the decision of the court in

Reyneke[152], is preferable to that in *Collins* on grounds similar to those that do not allow a wrongdoer to benefit from the fact that a plaintiff had the foresight to take out an insurance policy that covers him in the event of the materialization of the risk that was precipitated by the defendant. It may be that if justice is ot be done – as opposed to cold legal mathematics – then there should in cases such as that of *Collins*, be some kind of recognition in damages of the magnitude of the loss from the perspective of society and not only the plaintiff. Health in particular is a concept that cannot be reduced to sums of money. In a sense it is very much akin to concepts such as reputation or *dignitas*. It is not coincidental that in actions relating to health there is always likely to be a claim not only for patrimonial loss but also for non-patrimonial 'loss' described in terms of pain and suffering, loss of amenities of life, etc. The law recognizes this form of 'loss' and award damages sounding in money in respect thereof. Like a reputation, once lost, health may be difficult, if not impossible, to recover. Even more than a reputation, however, it is essential to the ability to enjoy life and it is central to the capacity to be human in the fullest sense. Why should a wrongdoer whose wrong is so profound that it destroys the capacity to appreciate the extent of that loss it had caused, not itself suffer loss as a result of its wrongdoing? If justice can be described in terms of the old adage, an eye for an eye, then this can to some extent explain why the decision in *Collins* offends a sense of justice even though mathematically and logically, it may be correct.

8.2.11 C v Minister of Correctional Services[153]

Facts

The facts as they appear from the headnote are as follows. During September 1993, while the plaintiff was a prisoner in the custody of the defendant at the Johannesburg Prison, a blood sample was taken from him which was later subjected to a test for the HIV virus. On the day in question the plaintiff was a

---

152 *Reyneke* fn 143 *supra*

153 *C v Minister* 1996 (4) SA 292 (T)

member of a group of prisoners standing in a row in a passage in a hospital when he had been informed, together with the other prisoners, by K, a sergeant in the Department of Correctional Services employed as a medical health aid and as a nurse, that the blood test was for HIV and other transmissible sexual illnesses and that he had the right to refuse to undergo the test. This information was subsequently repeated to the plaintiff by K in the closed consulting room where the blood was taken, and in the presence of W, a prisoner assisting K with the drawing of blood. The plaintiff was accordingly fully aware that the test was, *inter alia*, for the HI virus and that he had the right to refuse to be tested when he consented to undergo the test. The Department of Correctional Services had adopted the concept that informed consent was a prerequisite for testing prisoners and had specified what norms were applicable. The informed consent policy as determined by the department had already been in operation by March 1993. In terms of these norms prisoners who had been involved in high-risk behaviour (prior to imprisonment the plaintiff had been involved in homosexual relationships which placed him in the high-risk category) had to receive pre- and post-test counselling by a competent member and the prisoner's informed consent had to be obtained prior to the HIV test being administered. Pretest counselling entailed informing the prisoner of the meaning of HIV infection; the manner of transmission of the disease; the nature of the test and that consent was required; the social, psychological and legal implications of the test; what was expected if the result of the test proved positive; and the prisoner had to be granted time to consider the information before consenting to the test being administered. In the event of a positive blood test, post-test counselling required that psychologists, social workers and nursing staff be at hand to support the prisoner and to provide advice so that the result could be accepted. At the time that K took the blood sample of the plaintiff for the HIV test he had been unaware of the norm of informed consent adopted by his department. The plaintiff, who was subsequently advised that he had tested positive for HIV, instituted an action for damages in a Provincial Division against the defendant on the grounds of alleged wrongful invasion of his right to privacy.

Judgment

Kirk-Cohen J observed that consent is a defence to many acts which would otherwise be a delict. An obvious example is consent to surgery and that in recent years the concept that consent must be 'informed consent' has found favour with South African courts. In regard to surgery, he noted that informed consent postulates full knowledge of the risks involved and, after being made aware thereof by the surgeon, the patient is then entitled to exercise his fundamental right to self-determination. He referred to *Seetal v Pravitha and Another* NO[154] where it was stated in the headnote that a blood test on an adult without his consent is unquestionably an invasion of his privacy. On the other hand, the privacy of the individual is not in law absolutely inviolable. The debate about compulsory blood tests amounts to a showdown between the idea that the truth should be discovered whenever possible and the idea that personal privacy should be respected. Both ideas are important but neither is sacrosanct. The resolution of that debate will depend largely upon the store the Court sets by each idea, on its own sense of priority in that regard. Kirk-Cohen J noted that since the decision in *Seetal*, and with the ever growing scourge of the HIV virus and Aids, much thought has been given to what the minimum requirements of consent, with particular reference to blood tests for the HIV virus, should be. This too has been referred to almost universally as informed consent. He observed that speaking generally, it is axiomatic that there can only be consent if the person appreciates and understands what the object and purpose of the test is, what an HIV positive result entails and what the probability of AIDS occurring thereafter is. Evidence was led in this case on the need for informed consent before the HIV test is performed. Members of the medical profession and others who have studied and worked with people who have tested HIV positive and with Aids sufferers have developed a norm or recommended minimum requirement necessary for informed consent in respect of a person

---

154 *Seetal* 1983 (3) SA 827 (D)

who may undergo such a blood test. Because of the devastation which a positive result entails, the norm so developed contains as a requirement counselling both pre- and post-testing, the latter in the event of a positive result. These requirements have become almost universal in the Republic of South Africa. The judge quoted from the manual prepared by the Department of Correctional Services as to the protocol to be follows before testing a prisoner for HIV[155]. It was admitted that this was the standard in all prisons. He observed that he was not called upon to adjudge what the requirements of consent or informed

---

155 The manual was entitled "Management Strategy: AIDS in Prisons." The parts quoted by the court are reproduced below for the sake of convenience and to indicate the procedures that should be followed in order for consent to be informed in the case of HIV tests. The court noted that the Department of Correctional Services had itself adopted the concept that informed consent is a prerequisite for testing prisoners and had specified what the norms are. It noted that they were in accord with the views and suggestions of all major contributors in the country.
Paragraph 2.2 reads as follows: "Possible HIV infected persons: Once a person has been exposed to HIV (by high-risk behaviour) he/she can contract the HIV infection. For a period of three weeks to six months, blood tests can be negative and this person will show no signs or symptoms of the disease. This is known as the window period. During this period an infected person can pass on the virus to another person. For this reason the person is considered to be HIV infected and must be treated in the same manner as a positive HIV infected person."
Paragraph 5 provides: "Pre- and post-test counselling to prisoners who are/were involved in high-risk behaviour prior to admission: All individuals who are identified as being involved in high-risk behaviour should be counselled. Pre- and post-test counselling is of the utmost importance and should be done by a competent member (see Counselling to Prisoners point 14). Informed consent must be obtained from a prisoner prior to an HIV antibody test being administered. If the prisoner refuses permission for the tests to be done, it must be brought under (sic) the attention of the medical officer."
The relevant paragraph, or as it is here called 'point 14', reads as follows:
"14. Counselling to Prisoners
14.1 Pretest: potentially HIV infected persons. A prisoner may experience anxiety if he believes he may be HIV infected. The purpose of pretest counselling is to ensure that the prisoner is aware of: what HIV infection means, and is prepared for the progress of the infection; the manner of transmission of the disease and that high-risk behaviour must be avoided; the nature of the test and that his/her consent is required before the test can be administered; the social, psychological and legal implications of the test; and what is to be expected should the result of the test prove positive. The prisoner must be persuaded to avoid high-risk behaviour should the test be negative. The prisoner must also receive information to avoid the spreading of the disease if he is HIV infected. With the above information the prisoner could more readily give his permission for the test to be administered. However, the prisoner must be granted time to consider the information before he gives his permission for the test to be administered. Should the blood tests return a positive result the prisoner may be less shocked if he received pretest counselling.
14.2 Post-test counselling: negative blood test result. Should the blood test return a negative result, the prisoner will most likely feel relieved and happy. This is a crucial time during which to inform the prisoner: that he must understand that prior to the test he was engaged in high-risk behaviour, and that his behaviour has to change; that a second test will have to be administered after three months to ensure that the result remains negative. The virus can be inactive for three months while tests are negative. This is known as the window period. During this time spreading of the infection can take place while the infected person is not aware of his infection. That he may need the help of a psychologist or social worker to help him/her to change his behaviour.
14.3 Post-test counselling: positive blood test results. Comprehensive counselling to prisoners who are informed that their blood tests have proved positive is vitally important. Whereas some prisoners will be relieved to know that they are HIV-infected, others will be shocked to realise that they are infected. Psychologists, social workers and nursing staff should be at hand to support the prisoner and to provide advice so that the result can be accepted. Counselling must therefore be geared towards: helping the prisoner to accept the result; giving the prisoner guidance as regards breaking the news to relatives; giving advice as to the persons to whom the prisoner should disclose his condition; conveying the implications of any further pregnancies; convincing the prisoner that he/she can carry on with a normal life, as they are only HIV-infected and do not as yet have AIDS; signs and symptoms can take up to 10 years to manifest themselves; and convincing the prisoner to avoid high-risk behaviour, thus preventing the further spreading of the disease."

consent should be and to what extent personal privacy should, or should not, be respected as referred to in Seetal's case. The norm laid down by the department and, as a prisoner, the plaintiff was entitled to the right of informed consent as determined by the department which controlled his incarceration in prison. It was not granted to him and it is obvious to what extent the consent obtained fell short of the informed consent laid down by the department itself. Counsel for the defendant submitted that the deviation from the norm laid down by the department was minimal and not wrongful. That, said the court, depended on the circumstances. It referred to the following facts:

1. The first information about the test, its object and the right to refuse to submit to the test was communicated to the plaintiff as a member of a group of prisoners standing in a row in a passage. There was no privacy and little time to reflect.
2. No information on the right to refuse was communicated to each prisoner individually prior to his entering the consulting room.
3. What was repeated to each one of them in the consulting room was not said by anyone trained in counselling. It was also not said to each of them privately but in the presence of a co-prisoner, De Waal.
4. No reasonable time for consideration and reflection was accorded to each prisoner in the consulting room before he was asked whether he consented to the test.

In these circumstances, said the court, the deviation from the accepted norm of informed consent, including the fact that there was no precounselling, was of such a degree that the deviation was material and wrongful.

Kirk-Cohen J then turned to the question of whether the plaintiff had proved the necessary *animus iniurandi* required for the *actio iniuria*. He referred to *Whittaker v Roos and Bateman*[156] in which Solomon J stated that:

---

156 *Whittaker* 1912 AD 92.

"It seems to me that we have present here all the requisites which are necessary to found an action of injuria. Those requisites are well laid down by De Villiers in his work on the law of injuries as follows: First: "An intention on the part of the offender to produce the effect of his act"; in other words, the animus injuriandi. It is not necessary in order to find that there was an animus injuriandi to prove any ill-will or spite on the part of the defendants towards the plaintiffs; and it is quite immaterial what the motive was or that the object which the defendants had in view was a laudable one. It is sufficient that the injuries suffered by the plaintiffs were inflicted by the defendants, not accidentally or negligently, but with deliberate intention."

and noted that the Appellate Division in *Minister of Justice v Hofmeyr*[157] reaffirmed the principles laid down in Whittaker's case. Kirk-Cohen J found that the principles enunciated by the Appellate Division in Whittaker's and Hofmeyr's cases in regard to the definition of *animus iniuriandi* applied to the present case. In his opinion the fact that those cases dealt with imprisonment and the present case dealt with informed consent to undergo a blood test was of no consequence. They both deal with an invasion of privacy. Ill will, spite and motive are irrelevant. Despite Sergeant Kinnear's *bona fides*, the defendant was in the same situation as were the defendants in the two Appeal Court cases. Consequently, he ruled that the requirements of *animus iniuriandi* in the present case were the same as those laid down in the two cases *supra* and those requirements had been proved. In the result the plaintiff had proved the requirements of the *actio iniuriarum*. With regard to damages the court held that had the plaintiff received the pretest counselling postulated for informed consent, the emotional blow would, on the probabilities, have been diminished. It said that this must be weighed against the fact that, as an intelligent person, he did *de facto* consent when he was told what the test was for and that he had a choice whether to subject himself to that test or not. Also to be weighed were the circumstances under which the plaintiff was asked to consent. The court observed that counsel for the plaintiff in its view correctly conceded that the plaintiff was entitled to not much more than nominal damages if the defence version of the facts was true. It held that the present case was distinguishable,

---

157 *Hofmeyr* 1993 (3) SA 131 (A). The court also referred to Neethling *Persoonlikheidsreg* 3rd ed at p 260 and Burchell *Principles of Delict* [fn 28 *supra*] at p 191-2 in this regard.

on the facts, from that of *Jansen van Vuuren and Another NNO v Kruger*[158] since the plaintiff's case is not based on publication and, in addition, he did consent to the test being done.

In all the circumstances it considered an award of R1 000 adequate. Concerning costs Kirk-Cohen J observed that the plaintiff was entitled to test his right to informed consent. The submission was made that he was entitled to do so in the Supreme Court. For the defendant it was submitted that the plaintiff's case was based on false evidence, that there was no merit in it and he was not entitled to any costs, let alone Supreme Court costs. The trial lasted four and a half days. Much of the time was taken up on the disputed facts. The fact that the plaintiff was untruthful and his damages small, had to be balanced against the stance of the defendant. The defendant did not concede that the plaintiff could rely upon the policy of informed consent introduced by his department. Nor was there any explanation tendered why the policy, then already adopted and in practice, was not applied in September 1993 in the Johannesburg Prison. Weighing all factors, the court held that the plaintiff was entitled to establish that his right to privacy was breached and he was entitled to do so in the Supreme Court because the issue at stake was important. In the end, despite his own false evidence, he had been successful. On balance there were insufficient reasons to deviate from the norm that costs should follow the event.

Discussion

The issue of informed consent around which this case revolves has been discussed in some detail in the *Castell v de Greef*[159] the facts and judgment of which are given in the section on the private sector. The present case is of importance because it emphasises the weight of the right to privacy and the fact that it belongs to everyone. It also indicates the importance of the manner in

158 *Jansen van Vuuren* 1993 (4) SA 842 (A)
159 *Castell* 1993 (3) SA 501 (C); 1994 (4) SA 408 (C)

which proper consent, i.e. informed consent, is obtained. It is submitted that there is no difference in legal principle between informed consent for the purpose of testing for HIV and AIDS and any other life threatening disease. The fact that HIV and AIDS are a major problem in South Africa has thrown the spotlight on this disease but any temptation to assume that there are legal principles that are unique to the disease would be wrong. The same pre and post test considerations would apply to tests for other dangerous illnesses namely, the impact of a positive result on the patient's psychological and emotional wellbeing, the need to ensure that the patient understands the disease and how it should be managed, any lifestyle changes that may be necessitated in order to effect its management and the importance of observing drug regimens and the signs and symptoms to look out for in order to identify the need for immediate further medical attention. HIV and AIDS has merely thrown the spotlight on the importance of informed consent in a way that few other diseases probably could have done, largely due to the social stigma that is attached to it and the fact that it is presently incurable. It is submitted that the principle in the South African law of delict that recognises the possibility of damages for emotional shock will ensure that future cases in these circumstances are similarly decided whether the disease is HIV/AIDS or some other incurable, life threatening disease.

In the broader medical context this case has firmly established that ill-will or spite is not a prerequisite to establish the *animus injuriandi* necessary to ground an action for *injuria* in cases involving a lack of informed consent. It is important to distinguish the question of the invasion of privacy from that of the failure to obtain informed consent. It was, it is submitted, rather more the circumstances in which the consent was purportedly obtained[160], than the failure to obtain adequate informed consent that grounded the claim for *injuria*. Indeed the court found that the plaintiff had known of the purpose of the test, that he did *de facto* consent when he was told what the test was for and that he had a

---

160 At p3 07 of the judgment, Kirk-Cohen stated: "Also to be weighed are the circumstances under which the plaintiff was asked to consent, to which I have referred."

choice whether to subject himself to that test or not. If anything, the damages were awarded for emotional shock that he experienced when he was informed of the HIV positive test result. The court observed that the plaintiff's evidence was that the major upset occurred when he heard of the result of the test. As he said, when he heard of the result of the test, 'was dit vir my soos 'n doodvonnis'. It said that had he received the pretest counselling postulated for informed consent, the emotional blow would, on the probabilities, have been diminished. The question in this case, it could be argued, was not so much a lack of informed consent (since the plaintiff had consented to the test, knowing what it was for and also apparently knew the implications of being HIV positive - otherwise he would no have been as upset as he was on being told of the test result) as the lack of privacy in which it was obtained and the failure to take reasonable precautions to prepare the plaintiff for the possibility of a positive test result. The court found that on the probabilities he had not been "upset about the manner of the test to which he consented. Had he really been upset about the test itself, one would have expected him to have asked to see his confidante, Lieutenant Warren, at that stage. Equally, he did not ask to see her after the second test." The court had assessed the plaintiff as an intelligent person. Post-test counselling was successfully conducted. Although only the court was privy to every small factual detail of this case, it does seem that, by the standard for informed consent given by Kirk-Cohen J that "speaking generally, it is axiomatic that there can only be consent if the person appreciates and understands what the object and purpose of the test is, what an HIV positive result entails and what the probability of AIDS occurring thereafter is", there is a possibility that the plaintiff may in fact have given informed consent to the test. It is submitted that the failure to follow a specified protocol for the obtaining of informed consent does not necessarily mean that the consent is not informed (although the judgment in this case seems unfortunately to give the opposite impression) just as the rigid observation of a particular protocol for informed consent does not mean that it was necessarily informed. This is undesirable as it could have the effect of entrenching in law a protocol or policy

that should be subject to change with changing conditions and improved knowledge about the disease. A protocol simply increases the chances that the patient's consent is informed and serves as valuable evidence to this effect if it has been followed. Failure to follow the steps it outlines makes it more difficult to show that informed consent was obtained. Since medical interventions are *prima facie* unlawful, the onus of proving that informed consent has been obtained is likely to rest on the defendant.

It is submitted that there are many intelligent people who, knowing the implications of HIV infection and having received pre-test counselling, may well still be shocked at the news that they themselves have tested positive for the disease. With respect, it is unfortunate that the judgment in *C v Minister of Correctional Services* did not deal more precisely with the issues of informed consent in the light of the maxim *volenti non fit injuria* (and the principles discussed by Ackermann J in *Castell v de Greef*) in relation to the question of damages for emotional shock claimed under the *actio injuriarum*. Whilst it is clear that in principle informed consent to a test for HIV should be as capable of vitiating liability for emotional shock under the *actio injuriarum* as it should of vitiating liability for patrimonial loss in an action based on the *lex Aquilia*, the question as to whether consent was informed or not, should not be confused with the question of liability for emotional shock. Whilst the presence of informed consent would undoubtedly have a bearing on the cause of emotional shock and even the wrongfulness of the emotional shock, it is submitted that emotional shock is not a necessary consequence of failure to obtain properly informed consent and can still occur even though informed consent has been obtained. A reading of *C v Minister Correctional Services* tends almost to suggest that there was adequate consent to the test itself but that the plaintiff was not sufficiently prepared to receive a positive test result. In other words, although he knew what the test entailed, had consented to it and understood the nature of HIV and its consequences, he had not entertained the idea that he might be HIV positive. This may have been due to the fact that he was not given

sufficient time to consider whether or not he wanted to have the test and was not given sufficient privacy to raise any questions or concerns he might have had when the possibility of being tested was put to him. He was possibly expecting a negative test result. Such expectation may or may not have been precluded by the pre-test counselling. Although there was a requirement in the protocol of the Department of Correctional Services that pre-test counselling should include the social, psychological and legal implications of the test and what is to be expected should the result of the test prove positive, this does not necessarily mean that the plaintiff would have revised any belief he had that he was not HIV positive. It is respectfully submitted that whilst the conclusion in this case was ultimately the correct one, the analysis of the legal principles involved could have been clearer, especially given the fact that Ackermann J did such a clear legal analysis in the case of *Castell v de Greef* which was decided previously.

The failure to obtain informed consent will not necessarily amount in every case to an invasion of privacy. The problem in the present case was that the circumstances in which the informed consent was sought did not sufficiently recognise or protect the right of the plaintiff to privacy. It is submitted that in circumstances where the patient is unable to ensure that her surroundings are suitably private and that intimate conversations cannot be overheard by others, for example because she is confined to a hospital bed in an open ward, there is a responsibility upon those who can control the patient's environment to ensure that there is sufficient protection and respect for the patient's right to privacy. For example, it would be inadvisable to adopt the view that because a patient is not in a private ward, he or she has given up the right to privacy[161]. A patient's right to privacy in a health institution can be invaded in many ways. Allowing a patient to be questioned by a the press as to his or her condition or giving

---

161 In *National Media Ltd and Another v Jooste* (fn 27 *supra*) the Appellate Division observed that: "A right to privacy encompasses the competence to determine the destiny of private facts... The individual concerned is entitled to dictate the ambit of disclosure, for example to a circle of friends, a professional adviser or the public (cf *Jansen van Vuuren and Another NNO v Kruger* 1993 (4) SA 842 (A); Neethling *Persoonlikheidsreg* 3rd ed at 238-9)."

information to the press about a patient without his or her consent[162] or allowing a patient to be photographed[163] when he or she is not in a position to take steps

---

162 In *National Media Ltd and Another v Jooste* (fn 27 *supra*) Harms JA quoted the following words by Warren and Brandeis 'The Right to Privacy' (1890) 4 *Harvard Law Review* 193: and noted that they were well said: "The press is overstepping in every direction the obvious bounds of propriety and of decency. Gossip is no longer the resource of the idle and of the vicious, but has become a trade, which is pursued with industry as well as effrontery. To satisfy a prurient taste the details of sexual relations are spread broadcast in the columns of the daily papers. To occupy the indolent, column upon column is filled with idle gossip, which can only be procured by intrusion upon the domestic circle. The intensity and complexity of life, attending upon advancing civilisation, have rendered necessary some retreat from the world, and man, under the refining influence of culture, has become more sensitive to publicity, so that solitude and privacy have become more essential to the individual; but modern enterprise and invention have, through invasions upon his privacy, subjected him to mental pain and distress, far greater than could be inflicted by mere bodily injury. Nor is the harm wrought by such invasions confined to the suffering of those who may be made the subjects of journalistic or other enterprise. In this, as in other branches of commerce, the supply creates the demand. Each crop of unseemly gossip, thus harvested, becomes the seed of more, and, in direct proportion to its circulation, results in a lowering of social standards and of morality. Even gossip apparently harmless, when widely and persistently circulated, is potent for evil. It both belittles and perverts. It belittles by inverting the relative importance of things, thus dwarfing the thoughts and aspirations of a people. When personal gossip attains the dignity of print, and crowds the space available for matters of real interest to the community, what wonder that the ignorant and thoughtless mistake its relative importance. Easy of comprehension, appealing to that weak side of human nature which is never wholly cast down by the misfortunes and frailties of our neighbours, no one can be surprised that it usurps the place of interest in brains capable of other things. Triviality destroys at once robustness of thought and delicacy of feeling. No enthusiasm can flourish, no generous impulse can survive under the blighting influence."
In that case the issue was whether the appellants (the publisher of two weekly magazines, the Huisgenoot and You, and the news editor of the former) had wrongly breached the respondent's right to privacy by publishing details of private affairs for 'public delectation' (Melius de Villiers *The Roman and Roman-Dutch Law of Injuries* (1899) at 138 n 32). These magazines have the identical content, the one in Afrikaans and the other in English. The court in its judgment observed that: "The respondent had decided to make the private facts concerning her relationship with Botha public. This decision contracted her right to privacy because she no longer had the wish to keep these facts secret. The publication of the article could therefore not impinge on her right to privacy. This submission is unsound because it attaches no value to the agreement between the parties. As indicated, her willingness to reduce the compass of her privacy was subject to specific conditions or terms and they have not been complied with. That, according to Mr Burger, is beside the point because the cause of action is not one based upon a breach of contract. The response, I fear, is too simplistic. A right to privacy encompasses the competence to determine the destiny of private facts (see Neethling's comment on the judgment of the Court *a quo*: (1994) 57 *THRHR* 703 at 706). The individual concerned is entitled to dictate the ambit of disclosure, for example to a circle of friends, a professional adviser or the public (cf *Jansen van Vuuren and Another NNO v Kruger* 1993 (4) SA 842 (A); Neethling *Persoonlikheidsreg* 3rd ed at 238-9). He may prescribe the purpose and method of the disclosure (cf the facts in *O'Keeffe v Argus Printing and Publishing Co Ltd and Another* 1954 (3) SA 244 (C)...). Similarly, I am of the view that a person is entitled to decide when and under what conditions private facts may be made public. A contrary view will place undue constraints upon the individual's so-called 'absolute rights of personality' (*Minister of Justice v Hofmeyr* 1993 (3) SA 131 (A) at 145I). It will also mean that rights of personality are of a lower order than real or personal rights. These can be limited conditionally or unconditionally and irrespective of motive. The appeal was dismissed with costs.
In *Bernstein And Others v Bester and Others NNO* 1996 (2) SA 751 (CC) the constitutional court noted that: "In *Financial Mail (Pty) Ltd and Others v Sage Holdings Ltd and Another* [1993(2) SA 451 (A)] it was held that breach of privacy could occur either by way of an unlawful intrusion upon the personal privacy of another, or by way of unlawful disclosure of private facts about a person. The unlawfulness of a (factual) infringement of privacy is adjudged 'in the light of contemporary boni mores and the general sense of justice of the community as perceived by the Court'. Examples of wrongful intrusion and disclosure which have been acknowledged at common law are entry into a private residence, [*S v I and Another* 1976 (1) SA781 (RA); *S v Boshoff and Others* 1981 (1) SA 393 (T)] the reading of private documents [*Reid-Daly v Hickman and Others* 1981 (2) SA 315 (ZA)], listening in to private conversations [*S v A and Another* 1971 (2) SA 293 (T)], the shadowing of a person [*Epstein v Epstein* 1906 TH 87], the disclosure of private facts which have been acquired by a wrongful act of intrusion, [eg *Financial Mail (Pty) Ltd and Others v Sage Holdings Ltd and Another* supra] and the disclosure of private facts contrary to the existence of a confidential relationship. [Neethling *Persoonlikheidsreg* at 234 –8; Neethling, Potgieter and Visser *Law of Delict* at 334] (Footnotes omitted)

163 In *La Grange v Schoeman And Others* 1980 (1) SA 885 (E) for instance it was held that there is a difference between the publication of reports of judicial proceedings in which averments injurious to someone are made and the publication of the photograph of the person concerning whom the injurious remarks are made. Accepting without reservation the right of the public to be informed of what takes place in courts of justice and the desirability that they should be so informed, the question remains whether the public has the right to be

to avoid such intrusions could lead to a claim for invasion of privacy as much against the institution as against the primary offender. Allowing a patient's chart to hang at the foot of his bed so that all who pass by are able to peruse it at their leisure or posting diagnoses and treatments for patients in a particular ward up on a notice board in or outside of the ward in places where they are visible to any member of the public that passes by are other examples of a lack of respect for patient privacy and could give rise to legal action against the institution that allows such practices.

8.2.12 Silver v Premier, Gauteng Provincial Government[164]

Facts

---

informed, by means of a photograph in a newspaper, what the person, concerning whom injurious statements are made in court, looks like. Our law does not give publishers a privileged right 'to satisfy the curiosity of the public' by the publication of photographs of such persons. Kannemeyer J held in this case that while it might be that to publish a photograph of a person taken against his will would not, were that person not one concerning whom injurious allegations had been made in court, ground an action for injuria if that person had been 'catapulted into the public eye' against his will, this did not mean that the photographer could compel such a person to submit to being photographed or require him not to take steps to prevent such a photograph being taken and that that the applicant had no right to photograph the third respondent, if he did not wish to be photographed, and no right to claim to be entitled to do so at any time, even if third respondent did not object to being photographed. Kannemeyer J stated that he was unpersuaded that in our law, 'community custom' - to adopt the words used in the American Restatement - gives publishers a privileged right 'to satisfy the curiosity of the public' as to the appearance of the first and second respondents in the instant case. De Villiers, in his work on Injuries, at 24 and 25 says: "The specific interests that are detrimentally affected by the acts of aggression that are comprised under the name of injuries are those which every man has as a matter of natural right, in the possession of an unimpaired person, dignity and reputation. By a person's reputation is here meant that character for moral or social worth to which he is entitled amongst his fellow-men; by dignity that valued and serene condition in his social or individual life which is violated when he is either publicly or privately subjected by another to offensive and degrading treatment, or when he is exposed to ill-will, ridicule, disesteem or contempt. The rights here referred to are absolute or primordial rights. .. every person is bound to respect them; and they are capable of being enforced by external compulsion. Every person has the inborn right to the tranquil enjoyment of his peace of mind, secure against aggression upon his person, against the impairment of that character for moral and social worth to which he may rightly lay claim and of that respect and esteem of his fellow-men of which he is deserving and against degrading and humiliating treatment; and there is a corresponding obligation incumbent on all others to refrain from assailing that to which he has a right." While the first and second respondents cannot object to the publication of a report of the legal proceedings during which they were alleged to have been Mr Mohapi's assailants there is no justification in law which requires them to suffer the added indignity and inconvenience of having their photographs published in the press to satisfy curiosity and to make it possible for the public at large to identify them, as they go about their lawful avocations, as the people referred to in the press reports of the Mohapi case. If they are able to be so identified their right to 'tranquil enjoyment of peace of mind' will be assailed for their privacy will be invaded and they will be open to possible ill-will and disesteem. Further they will not be secure against aggression upon their persons. In this regard the fears mentioned by these two respondents for their personal safety and that of their families cannot be brushed aside.

164 *Silver* 1998 (4) SA 569 (W)

The plaintiff was admitted to the Johannesburg General Hospital on 20 April 1994 suffering from pancreatitis. By the time that the plaintiff was discharged, his ability to walk properly had been permanently impaired. The essence of the plaintiff's case was that his disability resulted from infection which entered and spread from a sacral bedsore, which he alleged he sustained in consequence of the negligent omission on the part of the nursing staff to apply proper pressure part care whilst he was in the general surgical ward of the hospital. The defendant argued that the plaintiff's disability was occasioned by complications which resulted from the pancreatitis from which the plaintiff was suffering on his admission. The negligence relied upon is that the nurses 'failed to take proper precautions in preventing the development of a pressure sore' and the plaintiff alleged that 'in consequence of the negligent conduct the plaintiff developed a pressure sore which resulted in necrotising fasciitis and ultimately resulted in paralysis of the lower limbs'.

It was common cause that after admission to the general surgical ward, the plaintiff's condition deteriorated rapidly; that he could not be admitted to the Intensive Care Unit ('ICU') immediately and that he was nursed in the general surgical ward; that when he was admitted to the ICU, the following observation was recorded: 'Both buttocks grey in colour? Bedsores'and that whilst the plaintiff was in the ICU, the 'bedsores' degenerated into an open wound about 11 cm square over the sacrum and extending to the buttocks on both sides. It was also common cause that the plaintiff was at risk for the development of pressure sores because of the following factors:

(a) The plaintiff is and was a diabetic. His circulation and the perfusion (movement of blood through the tissues) in his skin would be impaired as a result.

(b) The plaintiff had to be dialysed, which was done peritoneally (i.e. catheters were inserted into the abdominal cavity to circulate fluid). This gave rise to the risk that there would be a fluid leak and that the skin on which the plaintiff was lying would become wet.

(c) The plaintiff had a temperature. This would result in the plaintiff sweating and the skin on which he was lying would become moist.

(d) The plaintiff had to be intubated (i.e. a tube had to be inserted down his throat) so that he could be coupled to a respirator. To enable this to be done, the plaintiff had to be sedated - with the consequence that he was unable to move himself naturally.

(e) The plaintiff weighed, on his own evidence, approximately 87 kilograms.

(f) The plaintiff was treated with inotropic drugs and he was hypotensive. Each of these factors would in itself reduce the perfusion of blood in, *inter alia,* the skin.

Judgment

Cloete J observed that if the submissions made by the defendant's counsel were correct, then, accepting the plaintiff's hypothesis that the infection causing his disability could spread from a sacral bedsore, and if, in addition, such a bedsore is likely to have become a source of such an infection despite proper nursing care, the plaintiff cannot succeed in his claim based in delict as the factual test for causation would not have been satisfied[165]. The court said that it was aware

---

165 The court referred to *Siman & Co (Pty) Ltd v Barclays National Bank Ltd* 1984 (2) SA 888 (A) at 914C–918A and especially at 915E–*in fine*, where Corbett JA (as he then was) said the following about the application of the test for factual causation: "In many instances, however, the enquiry requires the substitution of a hypothetical course of lawful conduct for the unlawful conduct of the defendant and the posing of the question as to whether in such case the event causing harm to the plaintiff would have occurred or not; a positive answer to this question establishing that the defendant's unlawful conduct was not a factual cause and a negative one that it was a factual cause. This is so in particular where the unlawful conduct of the defendant takes the form of a negligent omission. In *The Law of South Africa* (ibid para 48) it is suggested that the elimination process must be applied in the case of a positive act and the substitution process in the case of an omission. This should not be regarded as an inflexible rule. It is not always easy to draw the line between a positive act and an omission, but in any event there are cases involving a positive act where the application of the but-for rule requires the hypothetical substitution of a lawful course of conduct (cf Prof A M Honoré in 11 *International Encyclopaedia of Comparative Law* c 7 at p 74–6). A straightforward example of this would be where the driver of a vehicle is alleged to have negligently driven at an excessive speed and thereby caused a collision. In order to determine whether there was factually a causal connection between the driving of the vehicle at an excessive speed and the collision it would be necessary to ask the question whether the collision would have been avoided if the driver had been driving at a speed which was reasonable in the circumstances. In other words, in order to apply the but-for test one would have to substitute a hypothetical positive course of conduct for the actual positive course of conduct." Cloete J said that although the judgment of Corbett JA was a minority judgment, it did, in his view correctly state the law and was an example of the detailed application of the broader test stated by the learned Judge of Appeal at 914F–915B, a passage referred to with approval in *Tuck v Commissioner for Inland Revenue* 1988 (3) SA 819 (A) at 832F—G.

that the plaintiff's claim was founded in contract and, in the alternative, in delict but said that it saw no reason why the *sine qua non* test should not apply equally to the contractual claim. The loss sustained by the plaintiff was said to have been caused by the breach of an implied term of an agreement that the hospital through its staff and employees would exercise due care, skill and diligence in providing nursing care. Precisely the same facts were relied upon as constituting a breach of the implied term as are relied upon as constituting a breach of the duty of care owed to the plaintiff. Thus said the court, it would be anomalous if the same result did not follow irrespective of the cause of action. Furthermore, the court held that although the question of remoteness of damage for breach of contract was approached (in the absence of a contractual stipulation as to the basis on which compensation is to be made) by determining whether the damage flowed naturally and directly from the defendant's breach or was such a loss as the parties contemplated might occur as a result of such breach[166], it must follow as a matter of logic that as a general rule, the test for factual causation would first have to be satisfied. Cloete J held that on the evidence, it seemed that if the plaintiff developed pressure sores where the skin was breached, as he did on his occiput and heels, despite adequate care in the ICU, he would, on the probabilities, have developed a bedsore at least as serious in the area which was at greatest risk and where bedsores occur most frequently, namely, the sacrum. Cloete J said he found it probable that the sacral bedsore which the plaintiff was likely to have developed anyway, would not have remained very superficial and that it would not have been fairly easy to manage and recoup the situation. He said that on the probabilities, the polymicrobial invasion would have taken place. The fact that other bedsores (those to the head and ankle) healed without complications, did not derogate from this conclusion, as those other bedsores, because of their location, were much less susceptible to contamination by fecal flora. The court held that assuming that the pressure sore on the plaintiff's sacrum was caused by the negligent omission of the nursing staff in the general surgical ward to give proper pressure part care (a question which it found

---

166 *Victoria Falls & Transvaal Power Co Ltd v Consolidated Langlaagte Mines Ltd* 1915 AD 1 at p 22 and p 54

unnecessary to decide), and assuming further that the plaintiff's disability resulted from a polymicrobial invasion which spread from that bedsore (a question which the court also found it unnecessary to decide), the plaintiff was not entitled to the damages which he claimed - as, on the probabilities, and given that the plaintiff's hypothesis as to how his disabilities occurred was correct, he would have suffered such damages irrespective of any negligence on the part of the nursing staff in the general surgical ward and, for all practical purposes, at the same time.

Discussion

This case involved the question of causation and whether the harm complained of would have arisen whether or not the nursing staff were negligent in caring for the patient. The court said that if the answer to this question was in the affirmative then there was no need even to consider whether or not the nursing staff had in fact been negligent in caring for the patient since the defendant could not be held liable for harm which would have occurred in the absence of his negligent and wrongful acts or omissions. The reason behind this approach is evident from the debates concerning alternative causes and the approach of the South African law of delict to the effect that the defendant is not liable unless his conduct in fact caused the plaintiff's harm[167]. If there is another factor present which would independently of the defendant have in any event caused the harm then causation cannot be attributed to the acts or omissions of the defendant. It is of significance that the court observed that it saw no reason why the *sine qua non* test for causation should not be applied to the contractual claims as well. The *sine qua non* test is a test for factual as opposed to legal causation[168]. In *Silver* the court made mention of the problem of alternative causes but was of the opinion that Silver's case was not so exceptional that the

---

167 See Boberg fn 28 *supra* p 380, Neethling, Potgieter and Visser, (fn 28 *supra*) p 174 fn 6; van der Walt and Midgley, *Delict: Principles and Cases* fn 28 at p 164

168 See also *Gibson v Berkowitz And Another* 1996 (4) SA 1029 (W)

sine qua non tests for factual causation could not be applied[169]. The court did not go into the question of negligence of the nurses in that case because it found an alternative cause for the patient's injuries that would have ousted the alternative cause of any negligence acts or omissions on the part of the nurses. Had the nurses in fact been negligent, the *sine qua non* test would in any event not have been satisfied and the defendant could not have been held liable.

Delictual liability for alternative causes is a subject that occupied the minds of Roman jurists and continues to occupy the minds of South African jurists[170]. The

---

169 At p 575 – 576 of the judgment the court observed as follows with regard to the *sine qua non* test: "There will, of course, be exceptions, such as that cited by Visser and Potgieter in *Law of Damages* (1993) para 6.3.2 at 80–1: '(W)here a building contractor X is not able to build because Y, who has to deliver cement, and Z, who has to supply bricks, both fail to honour their contractual obligations on the same day and thus cause damage to X (eg he loses profit). According to the conditio sine qua non "test", neither Y nor Z has caused damage since, if the breach of contract of each is notionally eliminated, the damage does not fall away!'
The learned authors express the view that common sense must be employed in such cases - an approach emphasised by Corbett JA in *Siman's* case at 917 *in fine*–918A and employed by Lord Wright in *Yorkshire Dale Steamship Co Ltd v Minister of War Transport* [1942] AC 691 (HL) at 706 ([1942] 2 All ER 6) and by Beadle CJ in *Portwood v Svamvur* 1970 (4) SA 8 (RA) at 15F–G. The present is not, however, an exceptional case. In conclusion, on the applicability of the 'but for' test for causation, I would refer to the following passage in the unreported judgment (which I feel obliged to say I gave but in which Labuschagne J concurred) in *Aalwyn J Bezuidenhout and Another v Willie J Jacobus Rossouw h/a Riviera Eiendomme* (WLD, case No A3010/97, delivered on 15 May 1997): 'Gewoonlik waar daar bepaal moet word of 'n sekere gevolg deur die optrede of versuim van een van die partye regtens veroorsaak is, moet daar gekyk word na 'n verskeidenheid van faktore wat 'n waardebepaling deur die Hof verg. Die vraag of die eerste bekendstelling van die eiendom die eintlike verkooptransaksie veroorsaak het, is geen uitsondering nie. In *Alda Real Estate Ltd v Lipschitz* 1971 (3) SA 871 (W) te 873H–874D het Marais R die volgende gesê: "The law with regard to a matter of this kind is usually stated in the following form: The duty of the estate agent, if he is to earn remuneration by way of commission for selling property, is to introduce to his principal (the seller) a purchaser who is willing and financially able to buy the property, and he earns the commission if a sale is concluded with that purchaser at the stipulated price or a price ultimately proved to have been acceptable to the seller. A proviso has been added to the effect that the introduction of the able and willing buyer must have been the effective cause or causa causans of the sale. If a new factor intervenes causing or contributing to the conclusion of the sale and the new factor is not of the making of the agent, the final decision depends on the result of a further enquiry - viz, did the new factor outweigh the effect of the introduction by being more than or equally conducive to the bringing about of the sale as the introduction was, or was the introduction still overridingly operative? Only in the latter instance is commission said to have been earned. This enquiry is not a metaphysical speculation in the result of cause and effect. It requires, as is said in *Webranchek v L K Jacobs and Co Ltd* 1948 (4) SA 671 (A), a commonsense approach to the question of what really caused the sale to be concluded, or, to put it differently, as it is said in a restatement of the law in America, whether it is 'just' that the agent should receive credit and compensation for the work he has done for the seller. In regard to this latter version, it may be said in passing that this question has nothing to do with the amount of work the agent put into it. The mere furnishing to the prospective buyer of the principal's address or the location of the property offered may be sufficient to entitle him to claim commission from the seller, provided a line of cause and effect can reasonably be traced from the introduction to the conclusion of the sale.'
Die woorde wat ek gekursiveer het, is belangrik. Dit moet nooit uit die oog verloor word nie dat voordat die gewone vraag (soos in *Alda Real Estate v Lipschitz* (supra) uiteengesit) ontstaan, daar hier - soos in enige ander situasie waar oorsaaklikheid bepaal moet word - eers aan die *sine qua non* (ofte wel "but for") toets voldoen moet word. Met ander woorde, as daar nie gesê kan word dat, was dit nie vir die agent se optrede nie, die gevolg (verkoop van die eiendom) nie sou ingetree het nie, kan die optrede van die agent nooit as oorsaak van die verkooptransaksie bestempel word nie. Andersom gestel, as die verkooptransaksie sou plaasgevind het afgesien van enigiets wat die agent gedoen het, is die agent nie (ingevolge die gewone kontrak tussen 'n agent en die eienaar) op kommissie geregtig nie.'"

170 Neethling J, 'The Case of the Three Hunters, or Delictual Liability For Alternative Causes' 2003 *SALJ* 120 at p 263 points out that in *Fairchild v Glenhaven Funeral Services Ltd; Fox v Spousal (Midlands) Ltd; Matthews v Associated Portland Cement Manufacturers (1978) Ltd* [2002] 3 All ER 305 (HL) (paras 157-60), Lord Rodger

problem of the three hunters is as follows: X, Y and Z are hunters in a forest frequently visited by P. All three of them fire a shot to bring down a bird. One bullet kills P. While there is no doubt that all three acted negligently, it is unknown whether the fatal shot was fired by X, Y or Z. Thus there exists a situation of multiple activities in which each on its own would be sufficient to cause the harm but where it is not know which one in fact cause it. Neethling notes that modern legal systems proffer various solutions to the problem of the three hunters. He observes that South African law will deny delictual liability where the plaintiff cannot, on a balance of probabilities, prove who of X, Y or Z factually caused the harm. According to Neethling the Greek and Italian systems provide a more or less similar solution while German law, on the other and, holds each hunter liable in full as a joint wrongdoer since persons are regarded as joint wrongdoers even where it is unclear who caused the harm. It is also irrelevant, says Neethling, whether the hunters acted in concert or independently. He states that a similar result is reached in some jurisdictions such as the USA and the Netherlands, by reversing the burden of proof. The *via media* approach is also followed by quite a few countries according to

---

of Earlsferry notes that: "D 9 2 51 Julian 86 *digesta* contains a substantial extract from one of the most important works on Roman law, written in the second century AD, the high classical period of Roman law. In the *principium* Julian is discussing chap 1 of the *Lex Aquilia*, which gives the owner of a slave the right to claim damages if someone wrongfully 'kills' a slave. Julian considers whether someone "kills" a slave for these purposes if he mortally wounds him and later someone else attacks the slave who dies more quickly as a result. Julian takes the view, which was probably not shared by all jurists that both persons who attacked the slave should be liable for "killing" him. In support of that view he says in D 9 2 5 51 1 that it follows from the authoritative rulings of the old Republican jurists who held that where a slave was wounded by a number of people in such a way that it was impossible to say whose blow had caused his death, then all of them were liable under the *lex Aquilia*: "...idque est consequens auctoritati veterum qui, cum a pluribus idem servus ita vulneratus esset ut non appareret cuius ictu perisset, omnes lege Aquilia teneri iudicaverunt..."
This passage in Julian's digesta is referred to by the later writer Ulpian in D 9 2 11 2 Ulpian 18 ad edictum: "sed si plures servum percusserint, utrum omnes quasi occiderint teneantur, videamus. Et si quidem apparet, cuius ictu perierit, ille quasi occiderit tenetur: quod si non apparet, omnes quasi occiderit teneri Iulianus ait, et si cum uno agitur, ceteri non liberantur: nam ex lege Aquilia quod alius praestitit, alium non relevant, cum sit poena..."
Ulpian considers whether if several people strike a slave, all of them are liable for killing him. He says that if it is clear who struck the blow from which the slave died, that person is liable for killing him. But he reports Julian's view that, if this is not clear, then all of them are liable for killing him. Again the precise factual situation is not spelled out, but it looks as if Ulpian is considering the case of an attack on the slave by several people at once. Since only the actual person whose blow killed the slave is liable if his identity is known, Ulpian must, however, be thinking primarily in terms of the individual liability of the person who does the killing: it is only if you cannot tell whose blow proved fatal that Julian holds that all are liable for killing the slave. A separate rule is adopted for that situation.
I would like to take from these passages the clear implication that classical Roman jurists of the greatest distinction saw the need for the law to deal specifically with the situation where it was impossible to ascertain the identity of the actual killer among the number of wrongdoers. If strict proof of causation were required, the plaintiff would be deprived of his remedy in damages for the death of his slave. In that situation, some jurists at least were prepared, exceptionally, to hold all of the wrongdoers liable and so afford a remedy to the owner whose slave had been killed."

Neethling. Thus under Austrian law, the hunters will be held liable as joint wrongdoers only if the negligent shooting of each was highly dangerous. It does not matter whether they acted in concert. In Belgium the plaintiff will be compensated where every member of the hunting group negligently in concert participates in the damage-causing activity, and thus had collective fault in relation to the damage. In such circumstances, a hunter will be liable even if he can prove that his shot did not kill. Neethling observes that the position is similar in the French system where the theory of '*faute commune*' normally applies. But, he says, if the hunters were hunting separately, the theory cannot be resorted to and the hunters will not be liable because of the lack of factual causation. All these different solutions, says Neethling, were considered by the European Group on Tort Law. In its *Principles of European Tort Law* the group proposed the following solution to the conundrum of the three hunters:

"In case of multiple activities, where each of them alone would have been sufficient to cause the damage, but it remains uncertain which one in fact caused it, each activity is regarded as a cause to the extent corresponding to the likelihood that it may have caused the victim's damage."

Neethling states that in the case of the three hunters this means that each of them would, in principle be liable for one third of the plaintiff's loss of support since the likelihood that any of the three shots killed P, is similar. He submits that this solution can be justified on grounds of fairness, reasonableness and justice because although only one hunter caused the harm, it is impossible to prove who he or she was. It could thus have been any of them. Neethling notes that the solution is clearly based on policy considerations and not on traditional principles of delictual liability. He points out that the only delictual element that may perhaps be applicable is legal causation where the basic question is whether there is a close enough relationship between a person's conduct and the victim's loss that the loss can be imputed or attributed to such person in view of policy considerations based on fairness, reasonableness and justice. He notes further that the solution clearly introduces another form of delictual liability, notably, partial delictual liability for the delict of another person but that this

concept is not new because vicarious liability does more or less the same thing. Neethling emphasises the importance of the decision of the House of Lords in *Fairchild*[171] in which the court came to the conclusion that either A or B was liable for the plaintiff's damage and that the one who had paid had a right to claim a contribution from the other (in other words they were joint wrongdoers). The English law has thus started the process of departing from the requirement of factual causation (*conditio sine qua non*) for delictual liability in cases such as that of the three hunters. Neethling notes that this development is, for policy reasons, based on fairness, equity and reasonableness, more satisfying to one's sense of justice and therefore commendable. He submits, however that it is more honest and dogmatically preferable, to declare outright that liability is based on policy considerations and not on traditional principles of delictual liability. The preference, he states is for partial liability rather than the joint wrongdoer approach adopted by the court in *Fairchild.* In consequence he suggests that the partial liability approach should be accepted and implemented in South African law.

Van Rensburg[172] criticises the *sine qua non* test. His criticism is *inter alia* that it is based on a clumsy, indirect process of thought that results in circular logic. It requires the elimination of the alleged causal factor from a sequence of events to ascertain whether the end result would have been the same. However, he says, if one has to apply the same test in asking whether the remaining causative factors led to the end result then one ends up eliminating these as well which means that one ends up with a thought experiment in which there are no causative factors at all. It is submitted that this is a perfect example of the dangers of abstraction in law leading to a logical fallacy. The law cannot be divorced from its factual context. The only causal factor that is subject to the *sine qua non* test is the action or omission of the *wrongdoer*. The *sine qua non* test does not apply to all causal factors of an event – only to those which are attributable to the

171 *Fairchild*, fn 170 *supra*

172 Van Rensburg *Juridiese Kousaliteit* p 28-30. See Neethling *et al* (fn 28 *supra*) at p 174 -178 where they summarize all of the criticisms of the *sine qua non* test by Van Rensburg.

actions or omissions of the wrongdoer. The *sine qua non test* is not a test for causation in the abstract. It is seeking to answer the question as to whether factually speaking the actions or omissions of the *wrongdoer* caused the eventual harm. Since such actions or omissions are unlikely in real life to be the only causative factors of the harm, Van Rensburg's attack on the test fails.

8.2.13 Korf v Health Professions Council of South Africa[173]

Facts

On 19 April 1990 when she was approximately five months pregnant, the applicant consulted a Dr A C Harmse at a clinic in Witbank. He performed a sonar investigation and told her that everything was in order. That same evening she realised that something was wrong and on instructions of Dr Harmse she was admitted to Witbank Hospital, which is a state hospital. After a few minutes Dr Harmse arrived, looked at the sonar report of that morning and again told her that there were no problems as the sonar showed that everything was in order. The next moment he told her that the child would not live and that the foetus had to be removed. This he proceeded to do. He put the foetus on a trolley and, without ascertaining whether it was alive, he then left the room. The applicant's friend, Anita, after a few minutes noticed movement and told Dr Harmse that the child was alive. He responded by saying that these were merely the final spasms. Thereupon Dr Harmse went to the baby, ascertained that there was life and ordered an incubator. At this stage the baby was already blue. It was alleged that this constituted medical neglect which resulted in the baby becoming a quadriplegic.

---

173 *Korf* 2000 (1) SA 1171 (T)

The applicant lodged a complaint with the South African Medical and Dental Council against Dr Harmse on the basis of medical negligence and a committee of that council, after a preliminary inquiry on 18 March 1997, informed her that the explanation by Dr Harmse was noted and that no steps would be taken. The applicant was dissatisfied. The applicant never received any accounts or correspondence from the Witbank Hospital or Dr Harmse in respect of the birth. Despite numerous requests and personal visits to Witbank Hospital, the applicant could not succeed in obtaining the records of her confinement and treatment. She was informed that all relevant records were in the possession of the respondent (who was the successor in title to the previous South African Medical and Dental Council).

The applicant wanted to institute an action on behalf of her child against Dr Harmse and the Witbank Hospital on the grounds of medical negligence. She alleged that she needed copies of the contents of the file of the respondent on the complaint which she lodged against Dr Harmse for this purpose. The court observed that the application was preceded by 'a strange tug of war' between the applicant's attorneys and the respondent. The attorneys requested copies of the contents of the entire file, whereas the respondent required the attorneys to provide a list of items which they sought in order that this request could properly be considered. This list was not forthcoming as the attorneys' attitude was that they did not know what was in the file. The hospital records were not specifically requested but, on the other hand, the respondent never denied that it was in possession of the originals or copies of the hospital records which had allegedly gone missing from Witbank Hospital. On the probabilities said the court, the respondent was in possession of the hospital records as no proper inquiry could have been conducted without at least obtaining them. The court further observed that the respondent, strangely enough, was throughout very cagey about the contents of its file. It even refused to furnish the applicant with a copy of Dr Harmse's explanation or with its own reasons for not taking any steps against him.

The reasons why the respondent refused to give access to the file were as follows:

1. The applicant could not, it averred, engage in a fishing expedition without showing the relevance of the documents sought to the civil proceedings contemplated by her against Dr Harmse and Witbank Hospital. In the absence of such relevant and rational connection the applicant was not entitled to indiscriminate access to the contents of the file.

2. It said that it was obliged to protect the confidentiality of documents or facts which came before it whenever it conducts or has conducted an investigation in respect of a medical practitioner against whom a complaint of misconduct has been lodged.

3. The applicant was told by the respondent as long ago as 26 June 1995 that the documents sought by her were in the possession of Witbank Hospital over whom the respondent had no jurisdiction or control. This statement was incorrect as the annexure to the respondent's answering affidavit, the document referred to, contained no reference to these documents at all.

Judgment

The court observed that the second point relating to the confidentiality of documents or facts was without merit. It said that in as much as the alleged confidentiality was based upon the privilege of a doctor/patient relationship, the applicant herself was the patient. Van Dijkhorst J said he could not understand why the respondent was so evasive. It could have offered insight into all the hospital records, medical reports, sonars and X-rays, etc pertaining to the birth. It could have sent the applicant a copy of Dr Harmse's explanation and of the statement of the applicant's friend Anita. It could have concisely stated the

nature of other documentation it had and the reasons for its refusal to disclose the contents thereof. He stated that it is not the duty of the respondent to shield doctors from complainants, just as it is not the duty of the respondent to persecute them on behalf of complainants; but at least it should not create the impression that it is shielding medical practitioners from the 'laser beam of the truth'.

The respondent had contended that the applicant had not shown on the facts of the case a basis to procure access to the entire contents of the file. It argued that s 32 of the Constitution should be read together with item 23(2)(a) of Schedule 6 of the Constitution and that the applicant had not shown that the respondent is an organ of state or that the information sought by her was required for the exercise or protection of any of her rights. Van Dijkhorst J noted that section 23 of the Constitution of the Republic of South Africa Act (Act 200 of 1993, the interim Constitution) read:

'Every person shall have the right of access to all information held by the state or any of its organs at any level of government in so far as such information is required for the exercise or protection of any of his or her rights.'

He observed that in terms of s 233(1) of the interim Constitution, unless the context otherwise indicated, 'organ of state includes any statutory body or functionary'. The new Constitution of 1996, he noted, contains a different provision. Item 23(2)(a) of Schedule 6 thereof, pending national legislation, preserved the application of section 23 of the interim Constitution with a slightly amended wording:

'Every person has the right of access to all information held by the state or any of its organs in any sphere of government in so far as that information is required for the exercise or protection of any of their rights.

Van Dijkhorst J observed that there is an extended definition of organ of state. In terms of section 239 of the Constitution an 'organ of state' means -

'(a) any department of state or administration in the national, provincial or local sphere of government; or

(b) any other functionary or institution -

(i) exercising a power or performing a function in terms of the Constitution or a provincial constitution; or

(ii) exercising a public power or performing a public function in terms of any legislation,

but does not include a court or judicial officer;...'

The court said that it should be noted that the previous 'level of government' had become a 'sphere of government' but that this did not create a material difference. In *Ex parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa 1996*[174], the constitutional court apparently held the same view. Van Dijkhorst J said that it must further be noted that the 'statutory body or functionary' which previously could have been a component of an organ of state had been given a much more precise content. In *Directory Advertising Cost Cutters v Minister for Posts, Telecommunications and Broadcasting and Others*[175] it was pointed out that an organ of state is not an agent of the state, it is part of government (at any of its levels). Section 233(1) of the interim Constitution included in the term 'organ of state' a statutory body or functionary. In that case van Dijkhorst J had applied a narrower definition of the concept organ of state than was applied in *Baloro and Others v University of Bophuthatswana and Others*[176]. The test laid down was whether the state had control. This approach was followed in *Mistry v Interim National Medical and Dental Council of South Africa and Others*[177] and *Wittmann v Deutscher Schulverein, Pretoria and Others*[178] in respect of the

---

174 *Ex parte Chairperson of the Constitutional Assembly* 1996 (4) SA 744 (CC) (1996 (10) BCLR 1253) at 802E - 803A (SA)

175 *Directory Advertising Cost Cutters* 1996 (3) SA 800 (T)

176 *Baloro* 1995 (4) SA 197 (B)

177 *Mistry* 1997 (7) BCLR 933 (D) at p 947B - 948C

178 *Wittmann* 1998 (4) SA 423 (T) at p 454B

interim Constitution[179]. In all these cases, the test applied in order to determine whether a body or functionary was an organ of state was whether that body or functionary was directly or indirectly controlled by the state.

Van Dijkhorst J noted that the 1993 definition of 'statutory body or institution' had become 'any other functionary or institution'. He said he did not think that this was a material difference. He observed that the latter phrase was further limited in the definition, whereas the 1993 definition was limited by the nature of an organ of state. He asked whether the description set out in subpara (b) now extended the meaning of organ of state and noted that subparagraph (i) limits it to a power or function in terms of the national and provincial constitutions. He said that this did not bring about a difference as subsection (ii) limits it to a public power or public function in terms of any legislation. It does not bring about a difference insofar as the reference to public power is concerned. The remaining question for the court to decide was whether the reference to a public function in terms of legislation took the concept of 'organ of state' out of the control test. Van Dijkhorst J said that the answer depended on the meaning given to the words 'public function'. He noted that the three pillars of the state, legislative, executive and judicial, are referred to in section 239 and that the latter is expressly excluded. The executive arm is expressly mentioned in subpara (a) and the legislative one falls under subpara (b)(i) which can also encompass, the auditor-general, public protector, etc. They are all, said van Dijkhorst J, part of the machinery of state as is a functionary (or institution) exercising a public power. He said there is no reason to give the word 'public' when used in conjunction with 'function' in para (b)(ii) a meaning that would take it outside the context of 'engaged in the affairs or service of the public' and give it the meaning of 'open to or shared by all the people'. (Both these meanings were found in *The Concise Oxford Dictionary* for the word 'public'.) Van Dijkhorst J found that it followed that the more precise definition of the

---

179 Directory *Advertising Costs Cutters* (*supra*) was also followed in respect of the new Constitution in *ABBM Printing and Publishing (Pty) Ltd v Transnet Ltd* 1998 (2) SA 109 (W) at 113A - G and *Goodman Brothers (Pty) Ltd v Transnet Ltd* 1998 (4) SA 989 (W) at p 993G - 994H.

term 'organ of state' in section 239 of the Constitution was not intended to differ materially from the 1993 definition.

The court observed that the issue whether or not the respondent was an organ of state arose in *Mistry v Interim National Medical and Dental Council of South Africa and Others* and that in that case both Booysen J, who dismissed the applicant's claim for interim relief, and McLaren J, who dismissed the applicant's claim for final relief, applied the control test and concluded that the respondent's predecessor was not an organ of state. Van Dijkhorst J observed that the state is not in control of the respondent and that the respondent was thus not an organ of state. He noted that there were three requisites for the applicant to succeed in terms of item 23(2) of Schedule 6 to the Constitution to gain access to the documents. They were:

(1) the information must be held by the state or an organ of state in a sphere of government;
(2) the information must be required by the applicant;
(3) for the exercise or protection of any of her rights.

The applicant failed on the first requisite to prove that the respondent was an organ of state. There was, said the court, a further dimension. Witbank Hospital is a provincial hospital and therefore an organ of state. The court found on the probabilities that the respondent held the hospital records and other documentation (or copies thereof), whereas Witbank Hospital denied that it had them. It said that the respondent was not entitled to those records in its own right and could only hold them on behalf of Witbank Hospital. In these circumstances the first requisite would be met in respect of these particular documents. The court held that there was no debate about the second requisite. The applicant had a need for the documentation in order to proceed with the claim on behalf of her child against the doctor and the hospital.

As far as the third requisite was concerned the court noted that the stance taken by the respondent that the applicant was on a fishing expedition in an attempt to create a claim was invalid. The court said that *prima facie* she had a claim on behalf of her child and that the claim had to be bolstered by expert opinion based on the correct acts. These had to be ascertained from the hospital records and reports. Seen in this light, said van Dijkhorst J there could be no doubt that the information was required for the exercise of the rights of the child. He noted that in terms of the Bill of Rights contained in chapter 2 of the Constitution there were a number of rights some or all of which would have been affected by the alleged negligent conduct of the medical personnel at the birth of the child. There was a shortened life expectation (section 11); the right not to be treated in an inhuman way (section 12(1)(e)); the right to bodily integrity (section 12(2)); the right to health care services and emergency medical treatment (section 27 (i)(a) and (3)); and in particular, as a child, the right to basic health care services and to be protected from maltreatment or neglect (section 28(1)(c) and (d)). Furthermore, said the court, it would be borne in mind that the child's interests are of paramount importance in every matter concerning the child (section 28(2)). Consequently, the third requisite had been complied with.

The court held that the applicant was partially successful. She was not entitled to the entire contents of the respondent's file but only to that part thereof which emanated from Witbank Hospital. It said that she had therefore gained substantial success and should be awarded her costs. In as much as the respondent argued that the claim was for the entire file and that she failed to specify these documents, that argument could be countered with the answer that it lay within the power of the respondent to offer to the applicant those documents to which she was entitled and of which the respondent had the full details. The applicant's complaint was throughout that she could not furnish the respondent with the details thereof.

The court ordered that:

1. The registrar of the respondent must allow the applicant to inspect and make copies of all documentation directly or indirectly emanating from the records of Witbank Hospital pertaining to the birth of the applicant's child and its *sequelae*. These included but were not limited to bed records, medical records and reports, sonar investigations and X-ray investigations.
2. The respondent must pay the cost of the application.

Discussion

This case is of interest in a number of respects, the medical negligence of the doctor in question being possibly the least of them[180]. However it is included in this section because it illustrates a number of points which have been emphasised in this chapter not least of which is the balance of power between the doctor and the patient in terms of accessibility to information and the tendency of medical professionals to protect one another. The court reprimanded the Health Professions Council for apparently interpreting its role as protecting members of the medical profession rather than protecting members of the general public from the medical profession where there is a professional relationship between them[181].

The case also indicates the existence of legal entities which sit somewhere between the purely private sector and the public sector. In this instance, the Health Professions Council is the relevant entity but there are many other such councils established by legislation which falls into the health care arena. The

---

180 Although the apparent callousness with which he treated the applicant and her baby is shocking.

181 In *Veriava and Others v President, SA Medical and Dental Council, and Others* 1985 (2) SA 293 (T) it was held that having regard to the provisions of the Medical, Dental and Supplementary Health Service Professions Act 56 of 1974 and the rules published by the South African Medical and Dental Council in Government Notice R2278 in Government Gazette 5349 of 3 December 1976, the SA Medical Council is truly a statutory *custos morum* of the medical profession, the guardian of the prestige, status and dignity of the profession and the public interest in so far as members of the public are affected by the conduct of members of the profession to whom they stand in a professional relationship.

Medical Research Council, the Medical Schemes Council, the Medicines Control Council, the Allied Health Professions Council, the Dental Technicians Council, the South African Nursing Council and the Pharmacy Council are examples of such bodies.

In the context of the Constitution as it reads presently, there are essentially two questions in principle that are involved in the situation posed by *Korf*. The first is whether the courts would still be correct in applying the control test to ascertain whether or not councils such as the Health Professions Council are in organs of state. The second question is whether the fact that they are organs of state or not is material. This question is posed without a consideration of the provisions of the Promotion Of Access to Information Act[182] for the present. This is firstly because although the Constitution itself mandates this legislation, it has to be consistent with the Constitution in terms of section 2 of the latter[183]. Secondly, the nature of these councils is important because there is differentiation between the manner in which both the Constitution and the Promotion of Access to Information Act approach the right of access to records of public as opposed to private bodies.

In terms of section 32 of the Constitution,

(1) Everyone has the right of access to-

(a) any information held by the state; and

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

The definition of "organ of state" in the Constitution reads –

"organ of state" means-

(a) any department of state or administration in the national, provincial or local sphere of government; or

---

182 Act No 20 of 2000

183 Section states: "This Constitution is the supreme law of the Republic; law or conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled."

(b) any other functionary or institution-

(i) exercising a power or performing a function in terms of the Constitution or a provincial constitution; or

(ii) exercising a public power or performing a public function in terms of any legislation."

It is submitted that the Health Professions Council of South Africa and the other statutory professional health councils[184] fall squarely into part (b)(ii) of the definition of "organ of state" in the Constitution.

Furthermore, if one considers other legislation governing organs of state e.g. the Public Finance Management Act[185] and the question of whether or not they are public entities in terms of such legislation, this submission is further reinforced. Although the statutory professional health councils are currently not listed in Schedules 2 or 3 of the Public Finance Management Act, this is due rather more to a legal technicality than any intention on the part of the Legislature since the Act provides in section 47 (2) that the accounting authority for a public entity that is not listed in either Schedule 2 or 3 must, without delay, notify the National Treasury, in writing, that the public entity is not listed. Section 47 (4) of the Act states that the Minister may not list in Schedule 3 *inter alia* any public institution which functions outside the sphere of national or provincial government. Schedule 2 of the Act lists "Major Public Entities" while Schedule 3 lists "Other Public Entities" including "National Public Entities", "National Government Business Enterprises" "Provincial Public Entities and "Provincial Government Business Enterprises" If one considers the definition of "national public entity" in the Act[186], it is very clear that the Health Professions Council of

---

184 Others are the Nursing Council, the Dental Technicians Council, the Allied Health Professions Council, the Pharmacy Council and the soon to exist Interim Traditional Health Practitioners Council (in terms of the Traditional Health Practitioners Act that is presently a Bill before Parliament).

185 Public Finance Management Act No 1 of 1999 (PFMA)

186 In the PFMA 'national public entity' means-
(a) a national government business enterprise; or
(b) a board, commission, company, corporation, fund or other entity (other than a national government business enterprise) which is-

South Africa and the other statutory health professional councils potentially fall within the purview of this Act although they are not listed in Schedule 3. The objects of the Public Finance Management Act are to regulate the financial affairs and provide for appropriate corporate and financial governance of certain entities which can broadly be described as being of a public nature and so the question of whether or not an entity is an organ of state for this purpose should not necessarily be conflated with the question of whether or not an entity is an organ of state for other purposes. However, it is submitted that if an entity can or does fall within the purview of the Public Finance Management Act, this strengthens the force of the argument that that entity could be an organ of state. It also demonstrates the *public nature* of that entity which is an important consideration, it is submitted, when deciding questions such as those raised in *Korf*.

If one looks at the Promotion of Administrative Justice Act[187] "administrative action" means any decision taken, or any failure to take a decision, by-

(a) an organ of state, when-

(i) exercising a power in terms of the Constitution or a provincial constitution; or

(ii) *exercising a public power or performing a public function in terms of any legislation*;

[writer's italics]

Whilst it is not suggested that only organs of state act in terms of legislation, indeed the Promotion of Administrative Justice Act clearly acknowledges that private entities can also do so, it is submitted that if one looks at the functions of the statutory health professional councils, if one considers that they act only in terms of their founding legislation and that they owe their very existence to such legislation, that their income is based almost entirely upon fees provided for in

---

(i) established in terms of national legislation ;
(ii) fully or substantially funded either from the National Revenue Fund, or by way of a tax, levy or other money imposed in terms of national legislation; and
(iii) accountable to Parliament.

187 Act No 3 of 2000

legislation and the nature of the functions ascribed to them by that legislation, and the fact that they are very much regulatory bodies[188], the argument in favour of their being organs of state is strong. There is a significant difference between such councils and other statutory bodies falling under the auspices of the Minister of Health such as the Medical Research Council and the National Health Laboratory Services which are not regulatory bodies, whose central functions revolve around commercial transactions with both the public and private sectors and which do not fulfil a regulatory role. In fact these bodies perform functions which can be and are performed by private entities for profit every day. Medical research is not a public function and neither is the provision of laboratory services. The fees charged by these entities are fees for services whereas those charged by the statutory health professional councils are fees dictated by regulation and are designed to cover the costs of their administrative and operational functions – a totally different scenario. The incomes of the Medical Research Council[189] and the National Health Laboratory Services are dependent upon contracts for services concluded with various clients and have a distinctly commercial aspect. The contractual relationships entered into by the statutory health professional councils by contrast, are for services rendered to the councils by third parties in support of the work of those councils eg contracts for auditing, archiving and cleaning services, rental agreements, and employment contracts with staff.

---

188 For instance in terms of the Health Professions Act No 56 of 1974 one of the objectives of the Health Professions Council in terms of section 3 (f) is -
"subject to the provisions of section 15 of this Act, the Nursing Act, 1978 (Act 50 of 1978), the Chiropractors, Homeopaths and Allied Health Service Professions Act, 1982 (Act 63 of 1982), and the Pharmacy Act, 1974 (Act 53 of 1974), to control and to exercise authority in respect of all matters affecting the training of persons in, and the manner of the exercise of the practices pursued in connection with, the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in human kind;"

189 For instance in terms of section 4 of the Medical Research Council Act No 58 of 1991 the functions powers and duties of the Council include –

- undertaking research of its own accord; or
- undertaking research on behalf of the state or any other authority, or on behalf of any person or institution, or support such research financially;
- developing and utilizing the technological expertise in its possession or making it available to any person or institution in the Republic or elsewhere;
- entering into agreements with any person or, subject to the provisions of section 5, with any government or administration, upon such conditions as the MRC and that person, government or administration may agree;
- hiring or letting services and immovable property.

Since the decision in *Korf*, the Promotion of Access to Information Act[190] was passed and has come into operation. Many would argue that since the Act applies not only to organs of state but to private bodies[191] as well the arguments raised in *Korf* are now largely academic. However, what was demonstrated in *Korf* was a disturbing attitude on the part of the statutory council involved in obstructing a member of the public in enforcing the constitutional rights of herself and her child. The Department of Health is currently busy with amendments to the Health Professions Act to improve the accountability of the council and the professional boards in certain areas. Furthermore, as stated earlier the Promotion of Access to Information Act itself differentiates between rights of access to public and private bodies.

In the case of the former it simply gives a right of access provided that there exists no ground for refusal as provided for in the Act. It gives a right of access to records of the latter where this is required to exercise or protect a right provided that a request for access is made in the prescribed manner and there exists no ground for refusal contemplated in Chapter 4 of Part 3 of that Act[192]. There is thus a primary obstacle to any request for access to the records of a private body in that one must first show that the access is required to exercise or protect a right. The definitions in this Act of "public body" and "private body" are illuminating in the context of the present discussion.

In terms of the Promotion of Access to Information Act-

"public body" means-

---

190 Promotion of Access to Information Act No 2 of 2000

191 Section 1 of the Act defines 'private body' as-
" (a) a natural person who carries or has carried on any trade, business or profession, but only in such capacity;
(b) a partnership which carries or has carried on any trade, business or profession; or
(c) any former or existing juristic person,
but excludes a public body"

192 Promotion of Access to Information Act No 2 of 2000, section 50.

(a) any department of state or administration in the national or provincial sphere of government or any municipality in the local sphere of government; or

(b) any other functionary or institution when-,

(i) exercising a power or performing a duty in terms of the Constitution or a provincial constitution; or

(ii) exercising a public power or performing a public function in terms of any legislation;

whereas

"private body" means-

(a) a natural person who carries or has carried on any trade, business or profession, but only in such capacity;

(b) a partnership which carries or has carried on any trade, business or profession; or

(c) any former or existing juristic person,

but excludes a public body;

It is clear from the foregoing that for the purposes of the Act, the Health Professions Council would be classified as a 'public body' in terms of part (b) of the definition of that term and this is, with respect, as it should be. Any reliance on cases such as *Korf* to try to avoid the disclosure of the requested record on the basis that the Council is not an organ of state and therefore not a public body would be misdirection and legally incorrect. The emphasis in the Promotion of Access to Information Act, as in the Promotion of Administrative Justice Act, is on the *public nature* of the functions performed and the powers held by the entity in question. Of assistance in this regard is the fact that the function or power is performed in terms of legislation. It is therefore no longer legally correct to enquire whether or not an entity is an organ of state in deciding whether or not its records may be accessed in terms of section 32 of the Constitution. The Promotion of Access to Information Act makes it clear

that this is not the case. It is submitted, however, that even if it were the case, there is a strong argument for regarding the statutory health professional councils as organs of state on the basis of the current definition of this term in the Constitution itself. What the drafters of the Promotion of Access to Information Act appear to have done is take the wording of the definition of "organ of state" and incorporate it into the definition of "public body" in the Act so that for the purposes of section 32 (1)(a) of the Constitution, the word "state" must be read to include functionaries or institutions "when exercising a public power or performing a public function in terms of any legislation".

8.3 Summary and Conclusions

The thirteen cases discussed in this chapter indicate a number of important points with regard to the law of delict as it pertains to health service delivery in the public sector.

They illustrate the importance of ensuring the availability of skilled professionals who are capable of adequately performing the tasks entrusted to them. In a practical context this means, for instance, that the state must ensure the community service doctors are adequately and sufficiently supervised whilst performing their community service if it want to avoid being held vicariously liable for culpable homicide in circumstances similar to those in *R v van Schoor* and *S v Mkwatshana*. The sometimes critical shortages of nursing and other professional employees in the public health sector in particular creates significant delictual hazards for both the state and the employees who act outside of their scope of practice. Whilst section 38A of the Nursing Act can provide assistance up to a point, as can the approach of the law with regard emergencies, there is still a need to ensure that there are sufficient human resources with the varying levels of skill and expertise required to provide the wide range of health care services offered by the state. There is a high level of risk involved in the delivery of health care services when health professionals

are regularly required to perform activities outside of their normal scopes of practice due not to any emergency, but simply to severe shortages of the appropriate personnel.

The levels of expertise expected of a health professional employed in the public sector cannot be lower than those expected of a health professional in the private sector. The locality rule cannot be used to justify such an argument. Whilst the circumstances in which health professionals in the public sector fulfil their duties may be such that the services they are able to provide are of a lower standard in terms of the level of sophistication of the treatment techniques, or the luxury with which the patient is accommodated, due for instance to a lack of the latest technological equipment and an absence of carpets on the floor of the ward, this should not be conflated with the levels of skill required of such health professionals. The disparities between the public and the private sector in terms of the circumstances in which health care services are provided cannot be used to justify a lesser degree of skill employed by a doctor in the public sector as opposed to one working in the private sector in the same way that the environment of a country doctor cannot justify a lower level of skill than that of a city doctor although it may justify a less satisfactory outcome of the treatment. This point will be explored in more depths in the following chapter in discussing cases such as *Webb v Isaac*[193]. One must distinguish between the level of care and skill which the law requires the health provider to exercise it and the circumstances in which it is exercised. This point neatly demonstrates the importance of construing legal principles in the context of real life situations. The same level of medical care and skill applied in the outbuilding of a farm as in a high tech modern operating theatre is likely to yield very different results in terms of health outcomes. This does not mean that the doctor who treated the patient in the outbuilding has exercised less care and skill than the one in the high tech operating theatre.

---

193 *Webb* fn 100 *supra*

There are different schools of thought within the science and practice of medicine and other health professions just as there are in any other field of knowledge. The law must make allowances for this. The fact that a particular surgical technique is still practised in the public sector and is still achieving its desired result, despite the fact that it is no longer fashionable in the private sector, does not mean that the public sector practice is unreasonable in terms of the risks posed to the patient. Clinical protocols are some of the most hotly debated issues in the health service delivery environment since, even in medical practice, there is more than one way to skin a cat. In many instances the protocol that is adopted by a particular practitioner will be dictated by his or her own levels of confidence in it and in his or her ability to perform the tasks it requires. One cannot draw an adverse inference simply because a practitioner does not follow a protocol that is within the mainstream of clinical or surgical practice. It is however, important to draw the line between what is an established, although somewhat eclectic, school of thought on the one hand, and pure experimentation on the other. The National Health Act[194] makes provision for specific criteria involving informed consent by the patient to experimental treatment or treatment for research purposes.

The limitations of the law of delict in its capacity to compensate victims for the wrongs that have been done to them are nowhere more clearly seen that in the case of *Collins v Administrator Cape*[195]. However this case raises deep philosophical questions about various possible approaches to the value attached by society to human dignity and freedom in relation to the optimal utilisation of resources for the benefit of the greatest number of people. In the public sector in particular, these are often vexed questions as the case of *Soobramoney*[196] demonstrates. In the case of *Collins* the state could have been ordered to pay an award of damages that in some albeit abstract way equated to the inconceivable loss suffered by the child but those with a utilitarian perspective would ask – to

194 Act No 61 of 2003
195 *Collins* fn 128 *supra*
196 *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC)

what end? One must weigh up the factors that count in favour of such an approach against those that count against it. Would such an award of damages discourage similar future incidents any more than the guilt and anguish already felt by the health professionals involved? Would it ever make up to the child the life that she has effectively lost? Would it force the state to take other precautionary measures that were not already in place at the time of the incident? Would it 'hurt' the state to lose that amount of money? The chances are that the answers to most of these questions is "No". By contrast, if one did not make such an award in damages how many other patients could be treated with that money in an severely under resourced health system? How many other patients lives could be saved using the amount of that award? Should what is essentially taxpayers money be used to compensate a child who is not capable, effectively, of being compensated or should it be used to benefit other taxpayers who are in desperate need of health care services? These are hard questions involving matters of public policy that are not easy to resolve. It is submitted that the concept of fault makes them harder since there is a vague feeling shared by many that fault equates to blame and blame should attract some kind of adverse consequence for the party at fault. The unemotional purists will argue that this is the role of the criminal law since it amounts to punishment, but as has been discussed earlier, the issue is not that simple.

It is submitted that the right of informed consent has acquired a constitutional dimension. It wholly supports the constitutional rights to human dignity, privacy and bodily and psychological integrity. Although decision of the court in *C v Minister of Correctional Services*[197] is, it is respectfully submitted, correct, it is a pity that the court did not explore in greater detail the constitutional aspects of the subject of informed consent. Although the conclusion is drawn in this thesis that a separate category of delict – so-called constitutional delicts – is unnecessary, it is submitted that if there is one area of legal debate that clearly illustrates the weight and importance of the constitutional rights mentioned

197 *C v Minister* fn 153 *supra*

above, and the delictual consequences of their violation, it is the area of informed consent.

Health professionals cannot be expected to be 'their brother's keeper' in the sense that they can be held responsible for the delicts of their fellows. This topic will be covered in more detail in the following chapter but it is clear from the decision in *S v Kramer*[198] that health professionals who work in a team are entitled to rely on each other to each perform the tasks allotted to them. There is no legal principle that automatically holds them "individually and severably liable" unless of course they are in formal partnership with one another.

Health professionals are not required to exercise the highest possible standard of care but rather a reasonable level of skill and care such as would be expected of a reasonable person in their circumstances and with their background and training. However, this cannot be used as a justification for acting where one does not have the necessary level of care and skill because *imperitia culpae adnumeratur*. Young doctors, for instance, cannot use their youth and inexperience as an excuse for failing to exercise the necessary degree of care and skill.

The boundaries between the law of contract and the law of delict are thin and getting thinner at least in their application within the context of health service delivery. This is evident *inter alia* from the finding of the court in *Silver* that the *sine qua non* test of factual causation that is commonly applied to cases founded in delict can also be applied to a claim in terms of the law of contract. After all factual causation is factual causation irrespective of the branch of law that one is dealing with. This illustrates the highly artificial nature of the purist compartmentalisation of different areas of law by some courts and legal academics. Justice is a unitary concept. The Constitution emphasises this as it emphasises the interrelationships between the different rights in the Bill of

198 *Kramer* fn 99 *supra*

Rights. If these rights are interrelated then the law that upholds them cannot be compartmentalised to the extent that different areas of law are required for their enforcement. It is submitted that a contract for health services is no less affected by the constitutional rights to human dignity, equality, life, bodily and psychological integrity and privacy than is a situation in delict involving the provision of health services. The fundamental, underlying principles and values must remain the same because the Constitution is the law upon which all other law in South Africa is based.

Conscious regard must therefore be had, when dealing with cases based on the law of delict with regard to health service delivery, especially in the public sector, to the principles and values of the Constitution because of the number of constitutional rights involved in the delivery of access to health care services and also because access to health care is itself a right in respect of which the state is required to take reasonable legislative and other measures to ensure its realisation.