Chapter 9

Law of Delict In Health Service Delivery – Private Sector

9.1 Introduction

The principles of the law of delict as they pertain in the private sector are no different to those that are relevant in the public sector. The same elements are relevant and the same obligations, in essence, exist. From a constitutional perspective the responsibility of the state to achieve the progressive realisation of the right of access to health care services is a heavier burden but the right of access to health care services contained in section 27(1) of the Constitution does not restrict the right to the public sector. The horizontal application of the rights in the Bill of Rights is dealt with in section 8 of the Constitution in the sense that it is there stated in subsection (1) that the Bill of Rights applies to "all law". This includes the law that governs the private sector. Subsection (2) states that a provision of the Bill of Rights binds a natural or juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right. Obviously the private health sector must be allowed to make a profit in the rendering of health services because this is its *raison d'être*. One cannot expect the private health sector to take

on, at its own expense, the burden of treating the indigent or anyone else without hope or expectation or payment. Consequently, it is submitted that, except under emergency circumstances, the ability of a patient to pay a private provider for services he or she is requesting is a valid and important consideration in a decision of that provider whether or not to provide the required health care services. This said, it is submitted that a refusal by a private provider to give access to health care services to a patient who is able to pay, or who is funded by an insurance company or a medical scheme, would have to be well justified in order to show that there has been no violation of that patient's right of access to health care services. In the private sector, unlike the public sector, hospitals tend not to employ doctors, physiotherapists, radiographers and pharmacists although they do employ nurses and nursing assistants and may, now that the law relating to pharmacy ownership has changed, increasingly employ pharmacists. In the private sector a significant number of doctors dispense medicines whereas in the public sector, where doctors are employees of the provincial government that owns the hospital, this is not normally the case. Consequently the delictual risks for different kinds of providers in the private sector may differ from those to which the same kinds of providers are exposed in the public sector and issues such as vicarious liability may not be as prominent. However, the basic principles of the law of delict remain the same for both sectors. Indeed many of the issues affecting the private sector have already been discussed in the preceding section on the public sector. The purpose of splitting this section into chapter eight dealing with the public sector and chapter nine dealing with the private sector was to tidily organise the relevant material and make it easier to quickly identify and access the cases relevant to each sector rather than to suggest any significant dichotomy in the law of delict.

A study of the case law involving health service delivery is necessary in order to appreciate the contextual, practical application of the relevant principles of law and to gain an understanding of any differences that may arise as a result of the application of these principles in the private as opposed to the public sector. Although the legal principles themselves do not differ, the real life situation in which they are applied can sometimes, but not necessarily, affect the outcome. This is because of the many different variables at play in differing factual contexts. The point has been made repeatedly in this thesis that law does not exist in a vacuum and it is only through a consideration of its application in practice that it can be properly appreciated.

9.2 Case Law

9.2.1 *Mitchell v Dixon*[1]

Facts

The facts as they appear from the judgment of Innes ACJ are as follows. On 22 February 1913, the plaintiff consulted Dr Howden of Durban to whom Dr Mitchell was acting as a general assistant at the time. He complained of a pain in the chest, breathlessness and general discomfort. He was given a prescription and told to remain in bed under the care of his mother with whom he was then residing. Thereafter he was once visited by Dr Howden and several times by Dr Mitchell. The diagnosis of both doctors was that he was suffering from pneumo-thorax on the right side – a distention of the pleural cavity due to the presence of liquid or air. It was decided on 03 March to expose the chest cavity and the defendant took with him for that purpose an astra syringe fitted with a steel needle. Dr Mitchell did not employ an anaesthetic. He caused the plaintiff to recline on his left side with his right arm raised, the hand resting on his head and firmly held there by his mother. Then cautioning the patient not to move he inserted the needle between the ribs as a spot in his back. When the instrument was right in and before the defendant had pulled the piston out of the syringe, the needle broke short off at the shoulder. The cause of the breakage was one of the disputed points in the case. The defendant tried to recover the broken portion but failed to do so, it being deeply embedded and out of sight in the flesh and he at once went to call Dr Howden. Together they administered chloroform and made an incision into the cavity with the dual purpose of finding the needle and relieving the patient. According to them there was a marked escape of air but they did not find the needle which still remained in the patient's body although he recovered in all other respects. The plaintiff claimed damages on the basis of negligence.

Judgment

---

1 *Mitchell* 1914 AD 525

The court stated that a medical practitioner is not obliged to bring to bear upon the case entrusted to him the highest possible degree of professional skill but is bound to employ reasonable skill and care. The burden of proving that the injury was caused by the defendant's negligence, said Innes ACJ, rested on the plaintiff throughout and the mere fact that the accident occurred was not *prima facie* proof of negligence. He observed that the needle could have been fractured by causes beyond the control of its operator – for instance by the movements of the patient. Therefore the maxim *res ipsa loquitur* could have no application. Innes ACJ stated that a medical practitioner is not necessarily liable for a wrong diagnosis. No human being is infallible and in the present state of science even the most eminent specialist may be at fault in detecting the true nature of a diseased condition. He noted that a practitioner can only be held liable if his diagnosis is so palpably wrong as to prove negligence, that is to say, if his mistake is of such a nature as to imply an absence of reasonable skill and care on his part, regard being had to the ordinary level of skill in the profession. After examining the evidence the court observed that it could not be said that the defendant had made a negligently wrong diagnosis.

It was also argued that the defendant had used the wrong needle but Innes CJ noted that this argument broke down because he had used the needle that was supplied with the instrument and expert evidence showed that the majority of 'medical men' preferred a steel needle to a platinum one for this purpose. The court came to the conclusion on all the evidence that the defendant could not be found guilty of negligence in any of the respects averred by the plaintiff. It set aside the finding of the jury in the court *a quo* in favour of the respondent.

Discussion

This case is one of those precedents that have been used to justify the inapplicability of the maxim *res ipsa loquitur* to medical situations. As has already been stated there is no reason in logic why this should be so and it is the view of the writer that a departure from this principle would be in order and would be consistent with public policy considerations in evening out the balance of power between provider and patient. A further important point to note is that a medical practitioner is not necessarily liable for a wrong diagnosis since anyone can make mistakes. Reasonable

mistakes cannot attract delictual liability since reasonable mistakes lack the element of negligence. Claassen and Verschoor[2] point out that it obviously cannot be expected that a doctor who is called out at night to a remote dwelling in the countryside for an unexpected emergency will keep up the same standards as he would have maintained in a fully equipped hospital with adequate numbers of trained staff. The formulation in *Mitchell v Dixon* that a medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not has been referred to with approval in *Van Wyk v Lewis*[3], *Esterhuizen v Administrator Transvaal*[4], *Buls and Another v Tsatsarolakis*[5], *Coppen v Impey*[6] and *Pringle v Administrator Transvaal*[7].

9.2.2 Webb v Isaac[8]

Facts

The plaintiff's right thigh was broken by a falling beam. On the following day the defendant was called in to treat and set the leg. It was alleged that the defendant failed to use reasonable skill and care in his treatment and setting of same; that he negligently set and bandaged it; that he failed to use the proper splints; that he failed and further refused without cause to attend to the plaintiff thereafter or to provide proper treatment with the result that the leg set at an angle instead of in a straight position and became shortened by three inches. It was alleged that by reason of the defendant's negligence the plaintiff had to undergo an operation for the removal of a piece of bone from his leg and would have to undergo a second operation necessitating the re-breaking and re-setting of his leg in a straight position. The plaintiff claimed that he had suffered in health and in earning capacity and had incurred medical expenses and nursing expenses. He claimed £1000 in damages and costs. The defendant pleaded that on 14 October 1914 he was requested by one B C

---

2 Claassen NJB and Verschoor T *Medical Negligence in South Africa*
3 *Van Wyk* 1924 AD 438
4 *Esterhuizen* 1957 (3) SA 710 (T)
5 *Buls* 1976 (2) SA 891 (T)
6 *Coppen* 1916 CPD 309
7 *Pringle* 1990 (2) SA 379 (W)
8 *Webb* 1915 EDL 273

Torr the owner of the farm Glen Rock to proceed to the farm and to attend to two men of whom the plaintiff was one. Torr said he would pay the fees for such attendance. The state of the roads made it impossible to go out that evening so he went the following morning and treated and set the plaintiff's leg. The defendant denied that he failed to exercise reasonable care and skill in the setting and bandaging of the leg or that he failed to use splints proper for securing the permanent and proper setting of the leg. The defendant was only requested to pay one visit and he denied that he refused to attend the plaintiff thereafter. He also denied that he was responsible for setting the leg at an angle and thus for the subsequent operations which had become necessary. The defendant asked about the plaintiff's condition on several occasions and was always informed that he was getting on well. He explained that he did not care to go out again unless asked as he was afraid that it would look as if he was trying to run up his fees in view of the fact that Torr was a wealthy man. Medical evidence on both sides admitted that there was no proof of negligence and that even under the most favourable conditions in the case of about 15 percent of fractures of the thigh there was a shortening of from two to three inches. With one exception the medical witnesses were all of the opinion that under the circumstances the treatment had been right and proper.

Judgment

Graham JP in giving judgment stated that the law upon the duties of a medical practitioner and the amount of skill which is expected of him had been discussed in *Mitchell v Dixon*[9]. He referred to the fact 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. He noted that in Mitchell it had been pointed out that the burden of proof that the injury was due to the plaintiff's negligence rested throughout on the plaintiff and that the maxim *res ipsa loquitur* did not apply. He said that there are 'excellent reasons' for this rule of law because if the law required in every case that a practitioner should have the highest degree of skill, it would lead to the result that in remote country districts and even in country districts at no great distance from the large centres it would be impossible to

9 *Mitchell* fn 1 *supra*

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. The court considered the facts and the circumstances in which the defendant had to treat the plaintiff and observed that they were not ideal and that it would probably have been better to move the plaintiff to more suitable surrounding but said that there was no evidence to show that it would have been possible to do so. The evidence showed that there was no hospital in Molteno to which the plaintiff could have been removed and that the defendant was not aware that the plaintiff had any friends in Molteno to whose house he could have been taken. Under the circumstances, it was not prepared to say that the defendant acted unreasonably in treating the plaintiff in the house in which he attended him. The defendant stated that in applying the splint he realised it would have been better if it had been a little bit longer but at the same time he said he came to the conclusion that the splint was capable of performing the work for which it was required. The court said it was quite satisfied that the use of the Liston splint and perineal bandage was the best treatment under the circumstances. It said that it was clear from the medical evidence of the experts that the perineal bandage and the weight and pulley is not the highest and most skilful treatment which an injury of this nature could receive but it was equally clear that that treatment was a reasonable treatment for an injury sustained and treated in the particular circumstances of the case. The court observed that it was clear that the removal of the piece of bone from the plaintiff's leg was in no way occasioned by the treatment he had received from the defendant. The bone had been fractured by the falling of the beam and the piece was bound to come away sooner or later. It was impossible for the defendant to remove the bone at the time he set the plaintiff's leg and it was impossible for him to ascertain that there was a piece of bone which was likely to come away after the fracture. It was only after a radiograph examination that the precise nature of the injury was discovered and a decision on the removal of the bone could be taken.

With regard to the allegation that the defendant had failed to visit the plaintiff when called upon to do so the court stated that it thought it would have been far wiser had the defendant adopted one of three courses of action suggested by one of the expert

witnesses to the effect that he would have recommended the patient's immediate removal to hospital or on receiving a request for a second visit he would have told the plaintiff that he would pay a visit on a date which he would fix or else he would have stated that he was to be sent for by the plaintiff on a date to be fixed by him. The court said that there was a good deal of force in the argument that it is not a reasonable thing to expect that the patient should fix the date of the doctor's return visit and that the responsibility should be left upon the patient of sending for the doctor at any particular time he thinks fit for it would be quite impossible for an unskilled patient, on a farm remote from any doctor to know how his injury was progressing and to know the particular time when the doctor should pay his return visit.

The court said it thought that the doctor should have made a date with the plaintiff on which he would visit him in order to ascertain how his injury was progressing. It said it would have been 'a wiser and kindlier' thing. At the same time, however, it was impossible from the evidence to find that even if he had visited the plaintiff on a second occasion on the day on which it was alleged he had been sent for, he could have done anything to the leg. The court said it thought the plaintiff had acted unwisely in the matter of not paying a second visit and the question of fees ought not to have entered into his consideration. Knowing that the plaintiff was suffering from a severe injury, it would have been wiser had he made every sacrifice and paid a second visit in order to satisfy himself as to how the case was progressing. At the same time, said the court, had he paid a second visit there was nothing further that he could have done to prevent the patient's ultimate condition. There was a union of bone but not a proper union. The improper union was the caused by lack of sufficient extension and the lack of extension led to the shortening of the limb. A judgment of absolution from the instance with costs was handed down.

Discussion

It is submitted that the court in its reference to country doctors not being able to exercise the highest level of skill and care incorrectly conflated two issues. The test laid down in *Mitchell v Dixon*[10] that a doctor is required to exercise only reasonable

[10] *Mitchell* fn 1 *supra*

care and skill has not got anything to do with the circumstances in which he must treat his patient. Whether a doctor lives in a small country village or a large and bustling metropolis, it is submitted that the level of skill that he must exercise remains the same. It must be reasonable skill and not skill of the highest professional level. The reason for this, it is submitted, is because not every doctor is capable of exercising the highest levels of professional skill. To suggest otherwise would be to suggest that every physicist should be able to perform to the level of those who have won the Nobel prize for physics or that every lawyer should have the same level of professional skill as the most competent and knowledgeable judge. Reasonable skill sits in the middle of the Bell curve where most practitioners are likely to be found. Exceptional skill is not a common commodity. The reasonable skill must be applied within the circumstances in which the practitioner finds himself. This is the second element of the test. It is discrete from the first in the sense that it does not detract from the level of professional skill required of a practitioner no matter what his circumstances but it acknowledges that the actual level of skill and care that a practitioner is able to devote to his patient may have varying results, depending upon the circumstances. If one conflates these two elements of the test as the court did in *Webb v Isaacs* one starts getting into arguments that country doctors should exercise a lower degree of skill than city doctors when in fact it is not the level of skill that varies but rather the circumstances in which it is exercised[11].

---

[11] Carstens PA in 'The locality rule in cases of medical malpractice' 1990 *De Rebus* 421 states that in view of the inapplicability of the local rule on the uniform South African medical training generally and the rapid advancement of medical learning, the views of Strauss and Strydom, Van der Walt and Gordon and Turner and Price that it makes no difference to the level of skill and care required of a practitioner whether he is attending a patient in Cape Town or a remote village on the edge of the Kalahari desert can be supported in principle. However, there are certain considerations within the South African context which have a definite influence on the question as to whether locality in which a medical practitioner operates should be taken into account when deciding whether his conduct was negligent or not. He submits that a distinction can be drawn between the subjective capabilities of the medical practitioner himself (capabilities such as training, skill and expertise) and the objective circumstances in which the medical practitioner happens to find himself in a particular locality. Carstens says that while it is true that there is uniformity in the training of medical practitioners in South Africa and that the standard of training is in all probability comparable with the best in the world, it cannot be denied that South Africa is a developing country and is in many instances a Third World country. Therefore, although a doctor may be suitably qualified, possessing all the subjective qualities, training and capabilities to be a good doctor, should he be placed in a remote country district where there is a lack of medical facilities and infrastructure to support the effective practise of 'First-World' medicine, this must surely be a factor to be taken into consideration when evaluating his conduct in cases of medical malpractice. Carstens stresses, however, that he is not arguing that the medical practitioners in the cities are better than their counterparts in the country; the fact of the matter is that the city practitioner more often than not has access to better medical facilities than his counterpart in the country. The mere fact, says Carstens, that a doctor is practising in the country obviously does not 'license' him to be negligent and then blame his mishaps on the lack of proper medical facilities. The law still requires of a doctor a reasonable degree of skill, which is dependent on the particular circumstances of the case which he has under treatment. Carstens submits that the locality rule is nothing but an 'added particular circumstance' that must be given consideration when deciding whether the doctor's conduct was negligent or not. In his opinion locality where a medical practitioner operates will always be relevant in cases of medical malpractice until such time when it can safely be stated that the medical facilities and equipment in this country are equally available and accessible, irrespective of whether the medical practitioner chooses to practise in the city or in the country.
It is submitted that whether or not the level of medical facilities and equipment is the same throughout the country, the circumstances will still always have to be taken into account since it is the circumstances of *each particular* case that are relevant. Locality as Carstens correctly points out, is just another of those circumstances. To elevate it to a factor which

As regards the *res ipsa loquitur* rule, Carstens[12] argues that it should be applied in specific circumstances with regard to the proof of medical negligence. He advances some general principles for the effective application of the maxim[13].

---

can increase or reduce the actual level of skill and care required of the doctor (for the purposes of ascertaining negligence) is not correct. One should rather view this issue from the point of view of level of care and skill versus standard and quality of treatment. It is quite clear from the judgment in ***Webb v Isaac*** that although the quality and standard of treatment was not what it should have been ***because of the locality***, the level of skill and care required of the doctor remained the same. It was the standard of the treatment that he was able to render that was affected by the locality – not his level of skill and care. Indeed had the court come to the conclusion that another (reasonable) doctor with the same training and qualifications as the defendant, when placed in the same locality and other circumstances as the defendant, would have brought to bear a higher level of care and skill than did the defendant, the latter would have been found guilty of negligence.

12 Carstens PA 'Die Toepassing van *Res Ipsa Loquitur* in Gevalle van Mediese Nalatigheid' 1999 *De Jure* 19

13 Carstens states: "Dit moet beklemtoon word dat ***res ipsa loquitur*** slegs 'n feitlike en nie 'n resgvermoede is nie. 'n Hof word ook nie deur die stelreël gebind nie en is vry om elke geval selfstandig in die lig van die beskikbare feite te beoordeel…Daar kan wel omstandigehede wees wat *prima facie* toepassing van die stelreël in die mediese praktyk regverdig die anwesigheid van 'n instrument in die pasiënt se liggaam na afloop van die operasie; 'n infeksie wat op 'n inspuiting volg, die opdoen van aansteeklike siekte in 'n hospitaal, brandwonde teweeggebring deur 'n warm waterbottel in 'n pasiënt se bed; besering van 'n gesonde liggaamsdeel langsaan die aangetaste liggaamsdeel. Ten spyte van die gemelde *prima facie* omstandighede wat die toepassing van die stel reel in die mediese praktyk sou regverdig, toon die Suid Afrikaanse regspraak in die algemeen onwilligheid om hierdie stelreël met betrekking tot die bewys van mediese nalatigheid in die praktyk toe te pas. In ***Mitchell v Dixon*** het die hof geweier om die stelreël aan te wend waar 'n naald in die loop van 'n aspirasie afgebreek het. In ***Coppen v Impey*** het die hof eweneens geweier om die stelreël toe te pas waar 'n pasiënt ernstige brandwonde opgedoen het as gevolg van X-straal-behandeling: so ook ***Webb v Isaac*** waar 'n ledemaat korter was nadat 'n breuk geheel het en ***Allott v Paterson & Jackson*** [1936 SR 221 226] waar 'n pasiënt onder narkose beserings opgedoen het. Alhoewel die Suid-Afrikaanse positiewe reg in beginsel teen die aanwending van die stelreël in die mediese praktyk is, was daar nie altyd eenstemmigheid onder die geledere van die regbank ten aansien van ***Van Wyk v Lewis*** is 'n voorbeeld hiervan: Hoofregter Innes en appèlregter Wessels was nie bereid om te aanvaar dat 'n depper wat deur 'n geneesheer in 'n pasiënt se liggaam gelaat is na 'n operasie, die toepassing van die stelreël met 'n gepaardgaande afleiding van nalatigheid regverdig nie. Appèlregter Kotzé het egter die teenoorgestelde mening gehuldig. In sy uitpsraak beslis hoofregter Innes dat die stelreël nie die onus beinvloed nie en bevestig hy die beginsel dat die onus deurgaans op die eiser rus om nalatigheid te bewys. Appèlregter Wessels verwerp ***res ipsa loquitur*** uitdruklik en beslis dat die bewyslas op die eiser rus om nalatigheid te bewys…Die verskillende *dicta* met betrekking tot die aanwending, al dan nie, van ***res ipsa loquitur*** by bewys van mediese nalatigheid het positiewe sowel as negatiewe kritiek uit die geledere van verskeie skrywers ontlok. In navolging van die positiewe reg en die uitsprake van hoofregter Innes HR en appèlregter Wessels, huldig Gordon, Turner en Price die mening dat die stelreël nie toepassing behoort te vind by die bewys van mediese nalatigheid nie, en dat die bewyslas voortduurend op die eiser rus. Hulle voer aan dat ten einde die hof behulpsaam te wee, beide partye in mediese wanpraktyksake alles in hul vermoë moet doen om deskundige mediese getuienis voor die hof te lê. Indien die deskundige mediese getuies in so 'n mate van mekaar verskil dat dit vir die hof nie moontlik is om tot bevinding te kom en die saak op 'n oorwig van waarskynlikhede te kan beslis nie, het die eiser hom nie van sy bewyslas gekwyt nie en behoort die eis te faal. Gemelde standpunt is in wese net 'n bevestiging van die algemene beginsels van die bewysreg soos dit in die regspraktyk toepassing vind… Strauss en Strydom kritiseer egter die ondubbelsinnige verwerping van ***res ipsa loquitur*** deur hoofregter Innes en appèlregter Wessels en toon oortuigend aan dat die stelreël in gepaste omstandighede wel toepassing behoort te vind. Alhoewel Strauss aanvanklik 'n voorstander was van die aanwending van die stelreël in bepaalde omstandighede huldig hy tans in navolging van die regspraak 'n meer gemagtigde an versigtige standpunt…Na evaluering van die positiewe reg en die standpunte van skrywers word daar aan die hand gedoen dat ***res ipsa loquitur*** wel onder bepaalde omstandighede by die bewys van mediese nalatigheid aanwending behoort te vind in hierdie verband kan daar algemene 'beginsels' vir die effektiewe toepassing en aanwending daarvan in die mediese praktyk neergelê word:

(a) ***Res ipsa loquitur*** is prakties niks anders nie as 'n bewysreël wat deur 'n eiser aangewend kan word om die bewys van beweerde mediese nalatigheid aan die kant van die verweerder te vergemaklik. 'n Eiser behoort bloot 'n feitelike basis (wat op 'n absolute gegewe berus) voor die hof te lê, welke basis kousaal met die nadelige gevolg verbind moet word. Die implikasie hiervan is dat die eiser dan nie noodwendig deskundige mediese getuienis wat sy saak steun hoef voor te lê nie, aangesien die hof deur die basis wat gelê is in die posisie geplaas word om voorlopig 'n afleiding te maak (ten minste tot dié mate dat die verweerder op die verdediging geplaas behoort te word). Alhoewel daar nie 'n egte bewyslas op die geneesheer rus om te bewys dat hy nie nalatig was nie, rus daar 'n verpligting op hom ('n weerlegginglas') om 'n redelike verduideliking te gee van sy 'ongewone' handelswyse wat tot die nadelige gevolg aanleiding gegee het. Die praktiese implikasie van 'n redelike verduideliking sal noodwendig meebring dat die geneesheer dan deskundige mediese getuienis sal moet aanbied ten einde aan te toon dat sy optrede medies gesproke aanvaarbaar was.

(b) Die stelreël kan nóg ondubbelsinnig verwerp word nóg simplisties en dogmaties aangewend word bloot omdat die 'feite vir sigself spreek'. Daar moet nog steeds noukeurig op die algemene bewyslas op die eiser om op 'n oorwig van waarskynlikhede sy saak to bewys, terwyl die staat in strafsake die beskuldigde se skuld bo redelike twyfel moet bewys. As bewysreël doen ***res ipsa loquitur*** nie afbreuk aan hierdie algemene beginsels nie. Dit is bloot 'n hulpmiddel wat ten gunste van die eiser onder bepaalde omstandighede aangewend kan word ten einde sy bewyslas te vergemaklik analoog byvoorbeeld die aanbied van soortgelyke feite om 'n bepaalde afleiding te regverdig.

9.2.3 *Stoffberg v Elliott*[14]

Facts

The plaintiff claimed £10 000 in damages for assault. The plaintiff was admitted to hospital for surgical and medical treatment for cancer of the penis. Dr Elliott, who treated the plaintiff was an honorary visiting surgeon who assumed that the administrative procedures, including the obtaining of the patient's consent, had been

---

(c) Daar word aan die hand gedoen dat waar 'n eiser (in siviele sake) of die staat (in strafsake) op die aanwending van hierdie stelreël wil steun, die eiser dit as sodanig in sy pleitstukke moet pleit en die staat dit ook voor die aanvang van die strafregtelike verrigtinge aan die hof behoort te openbaar.

(d) Waar 'n eiser of die staat op die stelreël steun, behoort die hof die aanwending al dan nie, van die stelreël met omsigtigheid te bejeën; juis vanweë die prosesregtelike implikasies wat dit vir die verweerder of beskuldigde (na gelang van geval) mag inhou. In hierdie verband kan daar amper van 'n versigtigheidsreël, analoog aan die by enkel-getuies, gepraat word.

(e) Wanneer daar bepaal moet word of die stelreël aanwending behoort te vind al dan nie moet daar noukeurig gelet word op die elemente van onderskeidelik die delik of misdaad wat bewys moet word alvorens daar sprake van die deliktuele of strafregtelike aanspreeklikheid kan wees.

(f) In navolging van 'suiwere elementologiese' benadering is dit veral die element van kousaliteit wat by die moontlike aanwending van die stelreël van besondere belang is. Daar word in oorweging gegee dat eers bepaal moet word of daar 'n kousale verband tussen die hoogs ongewone gebeure (absolute gegewe) en die nadelige gevolg is, alvorens daar sprake kan wees van die moontlike aanwending van die stelreël. Só kan die voorbeeld genoem word van 'n pasiënt wat tydens 'n operasie aan 'n gebaarste blindederm en peritonitis beswyk. Tydens die toewerk van die pasiënt se buik, word 'n depper en 'n knyptang per ongeluk in die buik agtergelaat. By die ontdekking van die knyptang en die depper tydens 'n latere post mortem ondersoek kan dit nouliks betoog word dat die stelreël aangewend moet word bloot omdat daar nie aan die kousaliteitsvereiste voldoen is nie, aangesien daar geen *nexus* tussen die dood en die handeling is nie. In hierdie verband is die *dictum* van die appèlregter Wessels, naamlik dat 'the mere act that a swab is left in a patient is not conclusive of negligence' heeltemal korrek. Word die gemelde *dictum* effe aangepas om die element van kousaliteit te akkommodeer, verander die prentjie. 'The mere fact that a swab is left in a patient which swab caused the patient pain, suffering or bodily injury, can be conclusive of negligence.' 'n Verdere kwalifikasie sou seker bygevoeg word, naamlik... 'can be conclusive of negligence unless satisfactory (sic) explained'. So gesien is die bevrediging die kousaliteitselement 'n vereiste vir die aanwending van die stelreël. Eers dan raak die verduideliking van die geneesheer relevant en moet die vraag gestel word of sy optrede in die omstandighede voldoen het aan die objektiewe maatstaf wat van regsweë vereis word.

(g) Die stelreël behoort aanwending te vind waar die eiser se feite (absolute gegewe) voor die hof plaas wat 'n *prima facie* afleiding van nalatigheid regverdig. Voorbeelde van omstandighede wat as absolute gegewe beskou kan word wat die aanwending van die stelreël regverdig is die volgende: Waar 'n geneesheer tydends (sic) 'n operasie die verkeerde ledemaat amputeer of op die verkeerde ledemaat opereer; die aanwesigheid van instrumente in die pasiënt se liggaam na 'n voltooide operasie; brandwonde veroorsaak deur 'n warmwaterbottel in 'n pasiënt se bed; besering van 'n gesonde liggaamsdeel langsaan die aangetaste liggaamsdeel waarop geopereer is; 'n operasie op die verkeerde pasiënt of die verkeerde operasie op 'n pasiënt; brandwonde wat gevolg het op X-straalbehandeling; die toediening van die verkeerde medikasie of verdowingsmiddels of oordosis daarvan, veral waar dit bekend is dat die pasiënt allergies daarvoor is. Dit moet beklemtoon word dat daar nie 'n geslote lys van absolute gegewe of feite is wat die moontlike aanwending van die stelreël regverdig nie. Die omstandighede van elke geval sal aanduidend wees van die sodanige aanwending al dan nie.

(h) Beginsles van billikheid, prosedurele regverdigheid and grondwetlike oorwegings moet vereis dat die stelreël in bepaalde omstandighede aanwending sal vind. Vir die 'afwesige' leke-pasiënt, wat tydens 'n operasie onder narkose in droomland is, is dit haas onmoontlik om te bewys wat tentye van die operasie gebeur het, terwyl die deskundige geneesheer wat minstens in beheer van die operasie was met binnekennis daarvan, geen bewyslas dra nie. Die vraag ontstaan of besondere kennis of binnekennis nie as 'n factor beskou moet word wat die ligging van die bewyslas may beïnvloed of ten minste aanleiding behoort te gee tot 'n 'weerleggingslas' nie.

(i) Sodra 'n eiser/staat 'n feitelike basis met 'n kousale verband tussen die handeling en die gevolg voor die hof gelê het, is sodanige basis *prima facie* getuienis waaruit die moontlike afleiding van nalatigheid gekonstrueer sou kon word. Daar is dan 'n verpligting op die verweerder/beskuldigde... om 'n redelike verduideliking te gee van die aanwesigheid van die absolute gegewe of feite. Indien die verduideliking redelik is...het die eiser/staat ...nie sy saak op 'n oorwig van waarskynlikhede/bo redelike twyfel bewys nie en moet die aksie faal/beskuldigde onskuldig bevind word. Indien die geneesheer se verduideliking nie aanvaarbaar is nie, word die *prima facie* getuienis afdoende getuienis wat meebring dat die eiser/staat sy saak op 'n oorwig van waarskynlikhede/bo redelike twyfel beyws het en gevolglik met sy aksie moet slaag of skuldigbevinding regverdig....

(j) Erkenning behoort gegee te word aan *res ipsa loquitur* as bewysreël wat ten gunste van die eiser in bepaalde omstandighede geld. Sonder sodanige erkenning is dié stelreël totaal kragteloos en van geen praktiese nut nie. Die stelreël behoort nie bloot negeer te word omdat die aanwending daarvan waar dit inderdaad angedui is, die geneesheer in sy verdediging sal verontrief nie"

[14] *Stoffberg* 1923 CPD 148

followed. He was doing charitable work at the hospital. The patient's penis was surgically removed. The patient maintained that he had not given consent to the operation. The jury found for the defendant.

Judgment

Watermeyer J advised the jury of the nature of assault. He stated that in the eyes of the law every person has certain absolute rights which the law protects. They are not dependent upon statute or contract but they are rights to be respected and one of them is that of absolute security of the person. He said that nobody can interfere in any way with the person of another, except in certain circumstances. Any bodily interference with or restraint of a man's person which is not justified in law, or excused in law, or consented to, said Watermeyer J, is 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. He explained the term justified as follows: there are certain interferences with the body of another which are justified and perfectly lawful, for instance when a police constable arrests another under a warrant or when an executioner hangs a man[15]. With regard to the term 'excused' Watermeyer J said, for instance if one is moving in a crowd and bumps up against another person, that is not an assault; it is an excused interference. If an interference is consented to, said Watermeyer J, then it is not wrong. He used as an example the football matches played at Newlands or a boxing contest.

The declaration in *Stoffberg* alleged an unjustified, unexcused, and unconsented to interference. The plea admitted interference but said that there was consent to the operation albeit not express consent. It said that the consent was implied by the fact that the patient went into hospital and was admitted for treatment and thereby consented to undergo such surgical and medical treatment as was immediately necessary.

In this regard Watermeyer J pointed out that it is a question partly of fact and partly of law whether there was an implied consent to undergo such surgical treatment as was

15 The death penalty has since been abolished in South Africa and there is consequently no longer any justification in law for execution.. See *S v Makwanyane and Another* 1995 (3) SA 391 (CC)

considered reasonably necessary by the doctor. He stated that insofar as the legal question is concerned, a man, by entering a hospital, does not submit himself to such surgical treatment as the doctors in attendance upon him may think necessary. By going into hospital, said Watermeyer J, he does not waive or give up his right of absolute security of the person. He cannot be treated in hospital as a mere specimen, or as an inanimate object which can used for the purposes of vivisection. He remains a human being and he retains his rights of control and disposal of his own body. He still has the consent to say what operation he will submit to and unless his consent to an operation is expressly obtained, any operation performed upon him without his consent is an unlawful interference with his right of security and control of his own body and is a wrong entitling him to damages if he suffers any.

Watermeyer J said that it may be that there are many cases in which a doctor could perform surgical operations upon another person without that other person's consent. He used the example of a man who is picked up unconscious in the street and whose consent cannot be obtained for treatment necessary to save his life. In such a situation, said Watermeyer J, the operation could be performed without consent. Another example given was the case where a man is undergoing one serious abdominal operation and while his body is open the doctor finds there is something else seriously wrong. In order to save his life, it is necessary to remove that. In such a case, said Watermeyer J, the doctor would be justified. He pointed out that in the present case there was no such emergency and that it was admitted that consent ought to have been obtained and was not obtained owing to some oversight in the hospital so that the operation took place without consent and as such was a wrongful act and in infringement of the plaintiff's rights, not justified by urgency or excused upon any other ground.

Watermeyer J said that although no moral blame attached to Dr Elliott and that he was quite justified in assuming that the consent had been obtained in the ordinary course, this did not change the legal position. In law if a man commits an assault or if he is one of a number who commits an assault then it does not matter whose duty it was to ask for consent to that assault. If he consent is not obtained then all the persons concerned in that assault are liable to the plaintiff if the plaintiff suffers any damages. The judge said that the fact that consent was not obtained in the present case was not

so much Dr Elliot's fault as it was his misfortune and that it did not relieve him of responsibility because he was the man who actually performed the operation of cutting off the plaintiff's penis without his consent. Watermeyer J then went on to explain the principles of compensation and whether damages should be awarded in the present case. He stated that the rule is that unless there is an element of insult or unless the action is brought to establish a right, then the plaintiff cannot recover unless he proves some actual damage, that is, pecuniary loss or pain and suffering. He told the jury that they could not take into account other things such as mental or moral pain and suffering and explained that this action was one to recover damages for actual loss sustained rather than a claim of insult. Watermeyer J told the jury that if they thought that there was cancer and that the operation was necessary to save the plaintiff's life then they should still further consider whether he suffered any damage at all. The jury found for the defendant and judgment was entered for the defendant with costs.

Discussion

Watermeyer J referred in this case to the right of absolute security of the person. He also stated that in the eyes of the law every person has certain 'absolute rights' which the law protects. It is important to note that there is a distinction between a right of absolute security of the person and an absolute right of security of the person. The former relates to the security and the latter to the right. The courts have held that the fundamental rights contained in chapter 3 of the Constitution are not absolute[16]. Since

16 Froneman J in *Qozeleni v Minister of Law and Order and Another* 1994 (3) SA 625 (E) held that: "The fundamental rights protected by the chapter are enumerated (ss 8-32), but they are not absolute rights. Apart from the possibility of these rights conflicting with each other in a given situation, they are all also subject to a general limitation clause (s 33) and may even in certain closely prescribed circumstances be suspended under a state of emergency (s 34). Any alleged breach of the fundamental rights set out in chap 3 therefore necessitates a two-pronged enquiry (leaving aside for the moment the possibility of suspension under a state of emergency), viz, firstly, whether there has been an infringement of the right, and, secondly, if so, whether that infringement of the right is justified in terms of the limitation clause (s 33). It is not necessary to go further than our own case law in this regard to determine the proper incidence of the onus in such cases. The person alleging an infringement of a fundamental right would initially bear the onus of proving such an infringement, but, having done so, the onus of proving the justification for such an infringement in terms of s 33 would be on the person or entity relying on such justification. From the case law it is also quite clear that the latter onus is not merely one of rebuttal ('weerleggingslas') but a fully-fledged onus ('bewyslas') (*Mabaso v Felix* 1981 (3) SA 865 (A) at 876; *Minister of Law and Order and Others v Hurley and Another* 1986 (3) SA 568 (A) at 586J-589I; *Minister van Wet en Orde v Matshoba* 1990 (1) SA 280 (A) at 284E-I; *During NO v Boesak and Another* 1990 (3) SA 661 (A) at 673G-H)." In *Rudolph and Another v Commissioner for Inland Revenue and Others NNO* 1994 (3) SA 771 (W), Goldblatt J held that: "Firstly, it must be recognised that the rights and freedoms guaranteed by the Constitution are not absolute. These rights and freedoms may be limited by laws which are not contrary to s 33(1) of the Constitution." In *Soobramoney v Minister of Health, Kwazulu-Natal* 1998 (1) SA 430 (D), Combrinck J held that: "The case made out by the applicant mirrors what at present seems to be a popular conception that the rights created in the Bill of Rights are absolute and can be exercised and enjoyed without limitation. This is of course not so. The rights are by s 36(1) limited in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society. The rights are also limited by the rights of others. A right extends only so far as the point to where it

the constitutional rights have not necessarily replaced those recognised at common law, this would appear to be a fundamental difference between the constitutional right of freedom and security of the person of bodily and psychological integrity as contained in section 12 of the Constitution the common law right to absolute security of the person. The question is whether the Constitution has limited the scope of the right to security of the person so that it is no longer absolute or whether the absolute nature of the common law right remains unaffected by the fact that the constitutional rights are themselves not absolute. It has been held that the common law and constitutional law should not be treated as two distinct and separate branches of law[17]. It is submitted that in view of this, and the fact that constitutional rights are themselves not absolute, it is highly unlikely that the common law rights should continue to be regarded as such. In any event, if one considers the basis upon which the constitutional and other courts have justified their statements that the rights in the Bill of Rights are not absolute, it is that they can be limited by a law of general application and that they must be balanced against other rights. It is submitted that the same is true of common law rights. They can be limited by law and they must also be balanced against other rights, if not other common law rights, then other constitutional

---

does not infringe upon another person's right. So for instance, there is a right to freedom of expression but it is limited to the rights of others not to be defamed. The right to assemble, demonstrate and picket is limited by the rights of others to access and freedom of movement. A right is also limited where others enjoy the same right and are competing for recognition of such right." In *De Reuck v Director of Public Prosecutions, Witwatersrand Local Division, and Others* 2003 (3) SA 389 (W) Epstein JA stated: "I reiterate that the rights contained in the Bill of Rights are not absolute. Rights have to be exercised with due regard and respect for the rights of others. Organised society can operate only on the basis of rights being exercised harmoniously with the rights of others. Of course, the rights exercised by an individual may come into conflict with the rights exercised by another 98 and, where rights come into conflict, a balancing process is required." In *S v Makwanyane And Another* 1995 (3) SA 391 (CC) the constitutional court stated that "The rights vested in every person by chap 3 of the Constitution are subject to limitation under s 33. In times of emergency some may be suspended in accordance with the provisions of s 34 of the Constitution." Similarly in *Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others* 2000 (3) SA 936 (CC), the constitutional court stated: "There is a clear limitation of the right to dignity caused by s 25(9)(b) read with ss 26(3) and (6). Like all constitutional rights, that right is not absolute and may be limited in appropriate cases in terms of s 36(1) of the Constitution."

17 Chaskalson P, speaking for the full Constitutional Court in *Pharmaceutical Manufacturers Association of SA and Another: In re Ex parte President of the Republic of South Africa and Others* 2000 (2) SA 674 (CC) said: "I take a different view. The control of public power by the Court through judicial review is and always has been a constitutional matter. Prior to the adoption of the interim Constitution this control was exercised by the Courts through the application of common-law constitutional principles. Since the adoption of the interim Constitution such control has been regulated by the Constitution which contains express provisions dealing with these matters. The common-law principles that previously provided the grounds for judicial review of public power have been subsumed under the Constitution and, insofar as they might continue to be relevant to judicial review, they gain their force from the Constitution. In the judicial review of public power, the two are intertwined and do not constitute separate concepts."
Hodes AJ observed in *Pennington v Friedgood And Others* 2002 (1) SA 251 (C) that: "At para [41] [of the *Pharmaceutical Manufacturers Association* case *supra*] Chaskalson P stated that powers which were previously regulated by the common law under the prerogative and the principles developed by the Courts to control the exercise of public power are now regulated by the Constitution and, in response to counsel's submission, relying on the decision in Container Logistics to the effect that common-law grounds of review can be relied upon by a litigant and, if this is done, the matter must then be treated, not as a constitutional matter, but as a common-law one, Chaskalson P said the following at paras [44] and [45]: '[44] I cannot accept this contention, which treats the common law as a body of law separate and distinct from the Constitution. There are not two systems of law, each dealing with the same subject-matter, each having similar requirements, each operating in its own field with its own highest Court. There is only one system of law. It is shaped by the Constitution which is the supreme law, and all law, including the common law, derives its force from the Constitution and is subject to constitutional control.'"

rights given the existence of the latter. In this sense then common law rights are and were not 'absolute' either. In his judgment in Stoffberg, Watermeyer J pointed out that in effect the 'absolute' right to security of the person can be modified or limited by a number of different concepts namely justification, excusability and consent. It would seem that the term 'absolute' as used with regard to the right of security of a person in *Stoffberg v Elliot* is thus a relative term[18]. It is submitted therefore that in essence there is little or no difference between the common law right of security of the person and the constitutional right to freedom and security of the person and to bodily and psychological integrity. Even prior to the Constitution the courts were on the whole reluctant to concede the existence of absolute rights[19]. It is submitted that this is because the term 'absolute' tends to imply that there are no exceptions to the rule. As any lawyer in practice will confirm, it is usually upon exceptions to the rule, the grey areas between the black and white letter of the law, that legal practice and litigation are founded.

Boberg[20] notes that T W Price[21] rightly points out that Watermeyer J erred when he instructed the jury that, if the plaintiff has not in fact consented, Dr Elliott would have been liable even though he had justifiably believed that the plaintiff's consent had been obtained[22].

9.2.4 Van Wyk v Lewis[23]

18 One has a distinct sense of oxymoron here.

19 See for instance *Jansen van Vuuren and Another NNO v Kruger* 1993 (4) SA 842 (A) and *Simonlanga and Others v Masinga and Others* 1976 (2) SA 732 (W)

20 Boberg PQR *The Law of Delict: Aquilian Liability* Vol I at p 746

21 Price TW 'The Role of Casus Fortuitus Vis Major and Mistake in Action for Delict'1953 16 *THRHR* 1 at p9

22 Boberg (fn 20 *supra*) at p746 quotes him thus: This, says Price, was 'a clear and fatal misdirection on a point of law. On the facts as found Dr Elliott was not guilty of any *culpa*; the moral position was in fact also the legal position, and the learned judge clearly misconceived the fundamental nature of the Aquilian action...In this case it is plain that the plaintiff sued the wrong person and the learned judge should have directed the jury accordingly'. This argument says Boberg is susceptible of misunderstanding. One may think that *culpa* was not in issue, since Dr Elliott acted intentionally when he operated. But Price's point was this: Dr Elliott was without fault because his actual, subjective belief that the plaintiff had consented excluded consciousness of wrongfulness and hence intention, while the reasonableness of that belief excluded *culpa*. Watermeyer J was therefore in effect instructing a jury that Dr Elliott was strictly liable and that was a misconception of Aquilian liability and a 'fatal misdirection'. As Boberg says, in the event, justice triumphed when Dr Elliott escaped liability upon the rather quaint ground that the plaintiff had suffered no damage because without the operation he would soon have succumbed to cancer. This, of course assumed that he had no claim for *contumelia*, as indeed Watermeyer J expressly directed but the assumption is challenged by Amerasinghe CF 'The Protection of Corpus in Roman Dutch Law' (1967) 84 *SALJ* 56 who rightly says that assault is *per se* contumelious.

23 *Van Wyk* fn 3 *supra*

Facts

The facts as they appear from the judgement of Innes CJ are as follows. On 3 February 1922, the respondent, a physician and surgeon practising at Queenstown received a telegram for Dr Louw of Sterkstroom asking him to meet the appellant, who was arriving by train, with a view to an operation. The respondent arranged for her admission to the Frontier Hospital where he examined her the same afternoon. Her condition was so critical that an immediate operation was necessary. This he performed at 8 o'clock the same evening. The anaesthetic was administered by Dr Thomas and a qualified nurse on the hospital staff acted as theatre sister. The matron and another nurse De Wet were also in attendance. The patient's appendix, being inflamed and adherent, was removed. The gall bladder was also in a state of acute inflammation, much distended with necrosis on the surface and he decided to drain it. Having paced the field of the operation with swabs handed to him by the sister her made an incision and inserted a tube. This was attended with difficulty. There was a rush of highly septic matter to be dealt with and owing to the friability of the gall bladder, it was impossible to suture the opening so as to draw it around the tube. He put in more packing to prevent the spread of sepsis. At that stage he was warned by the anaesthetist that the patient should be taken off the operating table as soon as possible. He concluded the operation, removed all the swabs he saw or felt and being satisfied that they had all been accounted for to the satisfaction of the sister, he stitched the patient closed. The appellant, a young woman of 26 made a rapid recovery and was discharged from hospital on 19th February, by which time the wound had healed over. Between that date and January of the following year, the respondent saw the patient on several occasions. Some time after the operation the wound opened slightly, there was an oozing of pus and she informed the respondent that several gall stones had come through the opening. She complained of discomfort but not of pain. The last occasion on which the appellant consulted the respondent was in January 1923 when he found on examination, a slight swelling and tenderness in the region of the gall bladder which pointed, he thought, to a recurrence of the old trouble. Subsequently, on the 15th of February, the appellant claimed that she evacuated a piece of muslin the shape and dimensions of a small, packing swab with tape attachment. Under those circumstances she refused to pay the respondent's

account which had just been rendered but commenced an action for damages. Judgment for the defendant was given by the court *a quo* and the plaintiff appealed.

Judgment

The court first considered the question of whether the appellant's evidence could be accepted stating that her story, implying as it did a lesion of the bowel by ulceration or otherwise, and the consequent passage of the swab into the alimentary system was itself remarkable and was rendered more remarkable still by the absence of high temperature and other symptoms which might be expected to accompany this process. However, the medical evidence showed that though in the highest degree improbable, her account of what took place could not be dismissed as impossible. The court *a quo* accepted the appellant's account as being the truth and the Appellate Division then did the same. It then turned to the legal nature of the claim and noted that there was some discussion as to whether the claim had been framed in contract or in delict. One of the appellant's contentions assumed that her claim was contractual. Innes CJ observed that the line of division, where negligence is alleged, is not easy to draw for negligence underlies the field of both contract and delict (tort). He said that cases are conceivable were it may be important to decide on which side of that line the cause of action lies but said that the present was not such a case – that no mere omission was relied on nor was the basis upon which damages should be calculated in dispute. Innes CJ did say that, since the point had been raised, it was his opinion that the claim was based in delict. He observed that the compensation demanded was in respect of injury alleged to have been sustained by reason of the respondent's negligence and lack of skill and that while the duty to take care no doubt arose from the contractual relationship between the parties, it was duty, breach of which was actionable under the Aquilian procedure. Consequently, said the court, the respondent's liability depended on whether it was due to negligence or unskilfulness on his part that the swab was allowed to remain in the wound. He held that this could only be decided on consideration of the facts surrounding the operation but before turning to these he considered the standard of care that the respondent had to observe and the question of where the onus of proof lay. Innes CJ referred to *Mitchell v Dixon*[24] in which it was

[24] *Mitchell* fn 1 *supra*

held 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. In deciding what is reasonable, said Innes CJ, the court will have regard to the general level of skill and diligence possessed and exercised at the time by members of the branch of the profession to which the practitioner belongs. He said that the evidence of qualified surgeons is of the greatest assistance in estimating that general level and that their evidence may well be influenced by local experience. Innes CJ said that he intended to guard against assenting to the principle in some American decisions that the standard of skill which should be exacted is that which prevails in the particular locality where the practitioner happens to reside. The ordinary medical practitioner should, he said, exercise the same degree of skill and care whether he carries on work in the town or the country, in one place or another. The fact that several incompetent or careless practitioners happen to settle in the same place should not affect the standard of diligence and skill which local patients have a right to expect.

Innes CJ then turned to the question of onus of proof. He stated that the general rule is that he who asserts must prove. Consequently a plaintiff who relies on negligence must establish it. If, at the conclusion of the case, the evidence is evenly balanced, he cannot claim a verdict for he will not have discharged the onus resting upon him. Innes CJ noted that it was argued that the mere fact that a swab was sewn up inside the appellant's body is *prima facie* evidence of negligence which shifts the onus so as to throw upon the respondent the burden of rebutting the presumption raised – a difficult task, he said, in view of the lapse of time between the operation and the trial. The maxim *res ipsa loquitur* was invoked in support of this argument. The court said that the maxim means simply what it says – that in certain circumstances the occurrence speaks for itself. It noted that the maxim was frequently employed in English cases where there was no direct evidence of negligence and that the question then arises whether the nature of the occurrence is such that the jury or the court would be justified in inferring negligence from the mere fact that the accident happened. It is really, said the court, a question of inference. Innes CJ stated that it was no doubt sometimes said that in cases where the maxim applies the happening of the occurrence is in itself *prima facie* evidence of negligence and that if by this is meant that the burden of proof is automatically shifted from the plaintiff to the

defendant, then he doubted the accuracy of the statement. He observed that the general principles on which the onus is transferred from one party to another during the course of a trial were observed in *Frankel v Ohlsson's Breweries*[25] and said that in the present case there was clearly no shifting of onus. The plaintiff alleged a lack of reasonable care and skill and the correctness or otherwise of that allegation can only be determined on a consideration of all the facts. Innes CJ stated that there is no absolute test – it depends on the circumstances. The nature of the occurrence is an independent element but it must be considered along with the other evidence in the case. In his opinion, said Innes CJ, the onus of establishing negligence rested throughout upon the plaintiff. He noted that the appellant's contention was not so much one of incompetence as one of carelessness on the part of the respondent. The court said that with regard to the removal of swabs at the conclusion of an operation a surgeon is bound to make such search and take such precautions as are reasonable under the circumstances. In view of the consequences involved, it said, the search must be careful and the precautions strict – anything less would not be reasonable. It said that whilst the testimony of members of the profession is of the greatest value on questions of this kind, the decision as to what is reasonable under the circumstances is for the court and whilst the latter will pay high regard to the views of the profession it is not bound to adopt them. Innes CJ observed that the duty of counting all the swabs and keeping a tally of those used inside the body and checking them as they come out is entrusted to the sister. He said there was ample evidence that this is a proper practice and one largely to be followed in present day surgery and that it was reasonable. The respondent admitted that he left the counting of the swabs to the sister. In a general sense the sister is under the orders of the surgeon but she also has independent duties to discharge and checking of the swabs was one of the most important. The court said that it could not say that a surgeon who leaves this task to a competent sister is on that account guilty of negligence. It said that the doctor's duty is to do his best for his patient and he should follow the course which his judgment tells him in his own case is the preferable one. The task of keeping a mental record of swabs used, a record that is valueless if not accurate, might distract one person more than another from that level of concentrating upon the problems of the operation which the interests of the patient demand. The respondent had made as careful a

---

25 *Frankel* 1909 TS 957

search as the critical condition of the patient permitted and the sister believed that all the swabs were accounted for. The respondent came to the same conclusion and proceeded to sew up the wound. In these circumstances, said the court, it was not prepared to differ from the finding of the court a quo in favour of the defendant that a charge of personal negligence had been established. On the subject of whether the respondent was answerable for the negligence of the sister, said Innes CJ, he did no propose to express any opinion since she was not a party in the present case. However, he did point out that she was not the servant of the respondent and that while she was under his general control during the operation, she was also a collaborator. Innes CJ said that whilst the court was sympathetic to the appellant, to uphold some of the arguments made on her behalf would render it difficult for a surgeon to concentrate all his energies upon the surgical problems of a critical operation and might render practitioners slow to undertake them. This, he said, would hardly be in the interests of the particular patient or the general public.

In a minority judgment Kotzé JA differed from the views of Innes CJ with regard to the question of *res ipsa loquitur*, saying that the placing of a foreign substance in the patient's body and leaving it there when sewing up the wound, unless satisfactorily explained, establishes a case of negligence. He quoted from *Hillyer v The Governors of St Bartholomew's Hospital*[26] where Kennedy LJ observed:

"It appears to me that, subject always to the reservation that I have stated in respect of the nature of the defendant's legal liability for the negligent acts or omissions of their professional staff, there was apart from the statements which two of the surgeons made subsequently to the plaintiff, and which were admitted in evidence without objection on the part of the defendant's counsel, a *prima facie* case on the issue of negligence on the facts which I have briefly set forth. I think that so far the plaintiff might, in the circumstances invoke the application of the maxim *res ipsa loquitur*."

The facts in this case were that a patient, whilst lying on the operating table in St Bartholomew's Hospital in an insensible state through the administration of the necessary anaesthetics had his left arm burned by contact with a heating apparatus under the table and his right arm was also bruised during the operation. The action was brought against the governors of the hospital, the plaintiff's case being that they were responsible in law for the negligence of the surgeons employed at the hospital.

---

26 *Hillyer* 1909 2 KB at p828

The Court of Appeal held that under the circumstances no liability attached to the governors of the hospital for negligence or unskillfulness of the surgeons in attendance at the operation. Kotzé JA said that the actual decision in *Hillyer* had no direct application to the present case but that the quoted observations of Kennedy LJ supported the view 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 or 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 that it is no doubt true that negligence may be manifested in many and various ways and in complicated instances the difficulties are usually in respect of the *onus probandi*. Not infrequently a plaintiff may produce evidence of certain facts which, unless rebutted, reasonably if not necessarily indicate negligence and in such cases the maxim *res ipsa loquitur* is often held to apply. Kotzé JA said that it seemed to him that the legal view in a case such as the present had been well summed up by Beven in his standard treatise on *Negligence*. According to him, to sew up a sponge or an instrument in a patient after an operation is evidence of negligence. He nonetheless concurred that the appeal should be dismissed but apparently on the basis that the defendant could not upon the evidence be held to be responsible for the sister not having kept a correct count of the number of swabs used and actually removed from the patient's body. Her duty in counting and checking the swabs is quite independent of the operating surgeon, he said.

Wessels JA in a minority concurring judgment stated that though the case was not founded on a breach of contract, it is one of those where the relationship between the parties arose out of a contract but where the act complained of is an injury of delict done in consequence of carrying out the contract. He said the delict grows out of a breach of duty which the law implied from the contract between the parties – the duty of the surgeon who contracts to operate, not to do so negligently. He said that the contract between a patient operated upon in a hospital and the operating surgeon is that the surgeon will perform the operation with such technical skill as the average medical practitioner in South Africa possesses and that he will apply that skill with reasonable care and judgment. Wessels JA said that the locality where the operation is performed is an element in judging whether or not reasonable skill, care and judgment have been exercised. He said that one cannot expect the same level of skill and care of

a practitioner in a country town as you can of one in a large hospital in a large city. In the same way one cannot expect the same skill of surgeons practising in South Africa as of surgeons practising in London, Paris or Berlin. Wessels JA stated that the relation of a hospital sister or nurse in a public hospital to a surgeon operating in that hospital is not that of master and servant not is it analogous to such relationship. The sister or nurse is an independent assistant of the surgeon though under his control in respect of the operation. He noted that the surgeon has no power to appoint her and she receives from him no fees. He also has no right to dismiss her and before and after the operation the doctor has no active control over her. Wessels JA noted that it had been decided in several cases that the doctor is in no way liable for what the nurse does after the operation to a patient in the ordinary course of those duties usually entrusted to a nurse[27]. The judge recognised that in operations some tem work is essential and that the work had become specialized 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". He said that to what extent the doctor should or should not rely upon the teamwork of the hospital assistances depends entirely on the nature of the particular case. As regards the burden of proof Wessels JA held that the onus of proof must rest upon the plaintiff all of the time. He said that the maxim *res ipsa loquitur* cannot apply where negligence or no depends on something not absolute but relative and that as soon as all surrounding circumstances are to be taken into consideration there is no room for the maxim. Wessels JA held that it is necessary for the plaintiff who seeks to recover compensation for the damage done to him to show that the defendant was in all the circumstances of the case in the wrong when he left the swab in the abdomen and that in so doing he had failed to use that reasonable skill, care and judgment which it was incumbent upon him to employ. The mere fact, said Wessels JA, that a swab is left in a patient, is not conclusive of negligence. Cases may be conceived where it is better for the patient, in case of doubt, to leave the swab in rather than to waste time in accurately exploring whether it is there or not as for instance where a nurse has some doubt but the doctor after search can find no swab and it becomes patent that if the patient is not instantly sewn up and removed from the operating table he will die. In such a case there is no advantage to the patient, said Wessels JA, to make sure that the swab is not there if during the time expended in

---

27 *Perionowski v Freeman* 4. F. & F. 977

exploration, the patient dies. Hence, he said, it seemed to him that the maxim *res ipsa loquitur* has no application in cases of this kind. Noting that almost all the surgeons called stated that a swab may be overlooked even though a high degree of care is shown and the more difficult the operation, the nearer the patient is to death, the more easily such an accident may happen, Wessels JA held that the appeal must be dismissed. He said that there was no doubt that the plaintiff owed her life to the skill of the defendant and the mere fact that in the exceedingly difficult operation, under the circumstances in which it was performed, he failed to find one of the swabs is not sufficient to justify the conclusion that he did not exhibit reasonable skill, care and judgment as an average surgeon would have displayed in the circumstances.

Discussion

This case was recently dealt with extensively in a doctoral thesis on the subject of the applicability of the maxim *res ipsa loquitur* in the health care context[28]. The maxim has already been discussed in detail in chapter seven and will not be further discussed here. The clear sympathy of the court for the doctor in this case (one almost gets the impression from the judgment that the court felt that the patient was ungrateful in that the 'medical man' saved her life) harks back to the days when medical paternalism was justified on the basis that 'medical men' had an almost mythical, not to mention mystical, knowledge of matters medical and their demi-god status in society was unquestioned by the common herd and may have lead in part to its finding that the maxim *res ipsa loquitur* was inapplicable to medical situations. As has been stated previously whenever the courts have considered the applicability of the maxim in the past they seem to run away from the idea that it shifts the burden of proof to the provider. Apart from the fact that the present writer cannot see why this is such an extremely bad idea in certain instances, the maxim does not shift the onus of proof onto the defendant. It merely transfers, an evidentiary burden that in the course of a trial can many times shift back and forth between the plaintiff and the defendant in much the same way that a tennis ball moves back and forth between players in a tennis match. The total score at the end of the game is what determines the outcome -

---

28 Van den Heever P 'The application of the doctrine of *res ipsa loquitur* to medical negligence actions: A comparative survey' (unpublished doctoral thesis 2002 University of Pretoria). He revisits *Van Wyk v Lewis* in extensive detail and comes to the conclusion that there was no reason in that case why the maxim should not have been applied and that the court in fact erred in stating that it was not applicable in the medical context.

not one particular volley. Strauss[29] points out that *Van Wyk v Lewis* has been strongly criticised but 'after all these years it still reigns supreme'. He notes that in the US the maxim *res ipsa loquitur* has gained a strong foothold and has become a powerful tool in the hands of lawyers acting for dissatisfied patients. There he says, it has been developed into a 'rule of sympathy' to combat the so-called 'conspiracy of silence' among doctors[30].

A further point to note from this landmark case are that the court refused to hold the surgeon liable for the failure of the theatre nurse that was assisting him to correctly count the swabs that were inserted into and removed from the patient's body and found that he was entitled to rely on her to do her part of the teamwork that was involved in a complicated and delicate surgical operation. The court rejected the idea that because the surgeon was in charge of the process this meant that liability for the negligent acts of others in the team could be laid at his door. This was confirmed more recently in the case of *S v Kramer and Another* in which a court held that a surgeon could not be held liable for the medical negligence of the anaesthetist assisting in the operation. In *Van Wyk* the nurse had not been cited as a party to the proceedings and the court rightly refused to discuss in any detail whether or not she was at fault. It is submitted with respect that the decision of the court in this regard was correct. It would not be conducive to effective teamwork in complicated medical and surgical procedures if the health professionals involved had a legal obligation not to rely on each other to perform their respective roles and fulfil their respective responsibilities in the larger operation. Furthermore, the fact that they should all be properly registered, licensed professionals recognised as such by their respective professional bodies is a factor which should be ignored. Just as a person prescribing a medicine should be able to rely on the fact that it has been registered upon the approval of the Medicines Control Council in circumstances where such approval may not be given without that august body being satisfied as to the safety, quality and efficacy of a medicine, so it is not for individual health professionals to question and mistrust one another's professional status at a time when the patient should be the main focus of attention. The question of the applicability of *res ipsa loquitur* has already been discussed.

---

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

30 Strauss fn 29 *supra* at p 245

9.2.5 *Dale v Hamilton*[31]

Facts

The facts appear from the judgment of Feetham J. The plaintiff claimed damages for an X-ray burn received by him in the course of an X-ray examination by the defendant. He alleged that the burn was caused by the lack of skill and neglect in treatment of the defendant in conducting the X-ray examination. The defendant admitted that the plaintiff was burned in the course of the X-ray examination he conducted but denied negligence. The plaintiff had been a shaft timberman on a mine and was a member of the Randfontein Estates Sick Benefit Fund Society. The defendant was a medical officer of the society and medical superintendent at the society's hospital. The plaintiff attended the hospital as an outpatient and was subjected to an X-ray examination for the purpose of diagnosing kidney stones. The plaintiff stripped to the waist and lay down on the couch on his stomach. A radiograph was taken and the plate developed. The defendant said it was underexposed and that he would take another. He took a second which was also underexposed and then a third which took a lot longer than the first two – as long as the plaintiff could hold his breath. The third plate, according to the defendant, was over exposed and so he took a fourth. The last plate he said, was the best of them all but still a little over-exposed. Three days after the X-rays, the plaintiff said his inside was painful and he had severe diarrhoea. After ten days he noticed a small red mark which gradually grew larger and became quite painful. He went to the defendant and was treated for it but is steadily became worse and on 24th February he had to take to his bed. On 28th February the defendant called and examined him and certified that he was unfit for work and in the afternoon the plaintiff went to hospital. His condition continued to get worse and in May the defendant advised that he should have an anaesthetic and have the wound scraped. The defendant said that the pain after the scraping nearly drove him mad. In the defendant's absence on leave in July, his locum asked leave to call in an expert radiologist to advise on treatment and thereafter the patient experienced a gradual improvement. All in all, the plaintiff spent more than 18 months in hospital.

---

31 *Dale* 1924 WLD 184

The defendant had only limited training and experience in radiography and the X-ray equipment at the hospital had been old when he first went to work there. Subsequently new X-ray equipment was purchased but some of the parts of the old apparatus were retained in an attempt to save on costs. The defendant had some training on the new equipment which was installed at least partly by the representative of the company from which the X-ray equipment was purchased. It was argued for the plaintiff that the fact that the defendant's burn was caused in diagnostic work and that it was severe was sufficient to establish a prima facie case of negligence and to shift the onus onto the defendant of proving that there was no negligence. The expert evidence supported this position.

Judgment

The court decided that the explanation given by the defendant for the burns was correct. The positioning of the couch relative to the X-ray tube was too close. It referred to the judgment in *Mitchell v Dixon*[32] and the *dicta* of Innes ACJ relating the to degree and care and skill expected of a medical practitioner. It also referred to the case of *Lymbery v Jeffries*[33], heard prior to Mitchell's case, and the fact that it was there held that work with X-rays was not work ordinarily or specially pertaining to the medical profession. Feetham J stated that if a doctor undertakes to do radiographic work, he must exercise in that work which he undertakes as a medical man, reasonable skill and care. But, he said, he was not sure that it made any difference whether he was a doctor or not. Anybody who undertakes radiographic work is obliged to exercise a reasonable degree of skill and care in doing that work. The question, said Feetham J, is what is the limit of the responsibility of a man undertaking radiographic work. Can it be said that he is entitled to take the factors with which he has to deal for the purpose of providing a suitable setting for carrying out a radiographic examination on trust or must he satisfy himself as to those factors? Feetham J held that in view of the evidence as to what constituted a setting and that the different factors in the setting are all interdependent a radiographer cannot escape liability if, owing to his having given an exposure which in view of the nearness of

32 *Mitchell* fn 1 *supra*
33 *Lymbery v Jeffries* 1925 AD 236

the X-ray tube to the patient is excessive, the patient is burned. In the present case, he noted that the defendant was not in the position of having ascertained from the expert who was employed to instal the apparatus, what the tube distance was. The court stated that it was unnecessary to determine whether or not the expert had given the defendant the necessary information because on his own admission the defendant neither asked where the tube was nor looked to see where it was yet on his own admission, the position of the tube was a vital factor in settling the time of exposures. The fact that the tube was as near to the patient as it was, caused the serious burn. The court found the defendant guilty of negligence in that he either did not exercise the care which he should have exercised being a trained man and having undertaken to use reasonable skill and care or he lacked the training necessary to enable him to use the tube which he was using. The court awarded damages for loss of earnings and also the effect of the injury on the plaintiff's future earning capacity since he could no longer return to his previous job of shaft timberman. It also awarded damages for pain and suffering and loss of general health.

Discussion

Claassen and Verschoor[34] note in connection with this case that according to Giesen and Fahrenhorst[35] a physician cannot defend himself by averring that he tried his best in accordance with his abilities and professional knowledge. If he is incompetent to treat a patient's specific illness he is obliged to refer the patient back to a specialist. A general practitioner will not, however be blamed for his lack of knowledge, training or experience if he undertakes specialist work in an emergency.

This is a clear case of *imperitia culpae adnumeratur* i.e. where lack of skill is reckoned as fault. In this particular situation it would seem that the mine medical scheme (the Sick Benefit Fund Society) was pennywise but pound foolish firstly in not wanting to spend the money to totally re-equip the X-ray unit in the mine hospital and secondly in allowing and possibly even encouraging a doctor who had no formal training or skill on the subject to do X-ray examinations of patients. Nonetheless it

---

34 Claassen and Verschoor fn 2 *supra* at p17

35 Giesen D and Fahrenhorst I 'Civil Liability Arising From Medical Care – Principles and Trends' *International Legal Practitioner*1984 9(3) p 80-85

was apparently he and not the Society that incurred the delictual liability. It is noteworthy that the court said that anybody who undertakes radiographic work is obliged to exercise a reasonable degree of care and skill. The court was not even sure that it made a difference whether the defendant was a doctor or not. This case can thus also be seen from the perspective of someone (whether a layperson or a professional) who is in control of a dangerous thing or is engaged in a dangerous activity[36]. A further point to note about this case is that the court would not allow the defendant to blame anyone else for the manner in which the equipment was set up since part of the duties of a radiographer is to make sure that all of the items of equipment that he uses are correctly positioned. This is because all of the factors are interdependent when taking an X-ray. The court noted that the defendant did not even attempt to make sure that the tube was correctly positioned and so it was unnecessary to consider whether the expert technician who had come out to install the equipment had given the correct information to the defendant. This case is not inconsistent with the decision in *Van Wyk v Lewis*[37] that the surgeon could not be held responsible for the failure of the theatre nurse to count the number of swabs used in and removed from the patient's body. It could be asked in relation to *Dale* why the defendant was not entitled to rely on the expert's correct positioning of the tube? However, it is submitted that *Dale* is distinguishable from *Van Wyk v Lewis* because in the case of the former, it was the task of the radiographer to make sure that the settings were correct in respect of each X-ray and each patient whereas in *Van Wyk*, it was not the task of the doctor to count the swabs. The work in *Van Wyk* had consciously been divided up and allocated before the procedure took place. In *Dale*, the expert technician had set up the equipment simply to show the defendant how it operated and that it was in working order. In *Dale*, the position of the tube could change depending on the patient's weight and size and the area of the body to be X-rayed. According the evidence, its position did not necessarily remain the same in respect of every X-ray.

---

36 Schutz JA in *Durr v ABSA Bank Ltd and Another* 1997 (3) SA 448 (SCA) stated: "I come towards my conclusion on the subject of negligence. The basic rule is stated by Joubert (ed) *The Law of South Africa First Reissue* vol 8.1 para 94, as follows:'The reasonable person has no special skills and lack of skill or knowledge is not *per se* negligence. It is, however, negligent to engage voluntarily in any potentially dangerous activity unless one has the skill and knowledge usually associated with the proper discharge of the duties connected with such an activity.'

37 *Van Wyk* fn 3 *supra*

9.2.6 *Richter and Another v Estate Hamman*[38]

Facts

The two plaintiffs, who were married to each other in community of property, sued the estate of Dr Hammann, formerly a neuro-surgeon practising in Cape Town, for damages for negligence in connection with a certain operation performed by him on second plaintiff on 12 April 1972. The second plaintiff was born in 1946, matriculated in 1964 and in 1967 obtained a university diploma in the teaching of retarded children. She married the first plaintiff in 1969. When she was a girl aged 14 she fell in a gymnasium on her coccyx and hurt it. She had pain off and on for many years and in 1970 received treatment from a Dr. Bruk in the form of a cortisone injection. In January 1972 she fell on the sharp edge of a chair and again injured her coccyx. She consulted her family doctor, Dr. Levy, who prescribed certain treatment which did not help her. Thereafter she was X-rayed and on 10 March 1972 saw an orthopaedic surgeon, Dr. Butler, who advised against the removal of the coccyx and prescribed conservative treatment in the form of pain pills and the use of a ring cushion. She was apparently not satisfied with this advice and after being told by a friend that Dr. Hammann might be able to help her she approached Dr. Levy and asked him to refer her to Dr. Hammann. This was duly done and the second plaintiff saw him in his rooms on 5 April 1972. Dr Hammann suggested that they first try an epidural block with saline and anaesthetic. On 7 April 1972 two injections of saline and novocaine were administered but they did not help, the coccyx remaining as tender as before. The second plaintiff saw Dr Hammann again on 11 April when he suggested that he should do bilateral phenol blocks of the lower sacral nerves as an outpatient at the Volkshospitaal. The second plaintiff went to the hospital on 12 April for the first of these injections and a right-sided unilateral block was performed, the intention being to inject the other side two days later. The second injection was, however, never administered because the first injection, although it achieved the desired result of relieving the coccygeal pain, had unfortunate consequences, namely, loss of control of

[38] *Richter* 1976 (3) SA 226 (C)

the bladder and bowel, loss of sexual feeling and loss of power in the right leg and foot.

Dr. Hammann died in September 1974 and the present proceedings were instituted in April 1975. The grounds of negligence originally relied upon were that Dr Hammann was negligent in advising a phenol block for the second plaintiff's complaint, and he was also negligent in the manner in which it was administered. On 4 February 1976, shortly before the trial commenced, notice was given of intention to apply for an amendment of the particulars of claim so as to include other grounds of negligence. The principal of these were that Dr Hammann failed to warn plaintiff of the dangers inherent in the procedure, and that Hammann failed to enquire into the second plaintiff's prior medical history, more particularly with regard to her bladder. These amendments were duly allowed.

Judgment

Watermeyer J noted that Dr. Hammann was a neuro-surgeon of considerable experience. He was the head of the teaching department of Neurosurgery at the University of Cape Town and the head of the clinical department of Neurosurgery at Groote Schuur Hospital. He had been in practice for many years and had the reputation of being an extremely careful and meticulous technician, well informed theoretically and a very competent surgeon. Three experienced neuro-surgeons gave evidence. Professor de Villiers who, apart from his other considerable qualifications, had since 1970 been head of the Department of Neurosurgery at Groote Schuur Hospital gave evidence for the plaintiff. For the defendant, Dr. Rose-Innes, Professor of Neurosurgery at the Stellenbosch Medical School and head of the Department of Neurosurgery at the Tygerberg Hospital, gave evidence and also Dr. Mendelow, practising as a neuro-surgeon, part-time senior neuro-surgeon to the Johannesburg Hospital and the University of the Witwatersrand and past president of the Society of Neurosurgeons of South Africa.

Phenol intrathecal blocks are usually done to relieve pain in cancer patients and for spasticity, and there was much debate in the evidence as to whether it was a permissible treatment for the treatment of coccydinia which, it was generally agreed,

was the condition from which the plaintiff was suffering. Professor de Villiers who examined the plaintiff on one occasion some six to seven weeks after the phenol injection, was fairly firm that he would not have given such an injection for what he described as ''n mindere kondisie'. He pointed out that since the second fall, a period of only 2 to 21/2 months had elapsed, that pain in the coccyx often takes a long time to clear up and that he would have advised conservative treatment for a long time. His reason for saying this was that there are dangers attached to an injection of this nature, particularly to the nerve supply of the bladder and bowel, and he did not think that the taking of such a risk was warranted for the relief of a benign pain such as coccydinia. He said that what had happened in the present case was that, although Dr Hammann was attempting to perform a unilateral block, i.e. on the right side only, the nerves S2, 3, and 4, on both sides had been affected and this resulted in damage to the nerve supply of the bladder, bowel and sexual organs. He readily conceded that this was a very unusual result - to use his own words 'very uncommon in any man's experience' - but nevertheless he would not have attempted it in this particular case. Professor de Villiers' opinion was based on his assessment of how bad the plaintiff's pain was but he accepted that in cases of coccydinia where the pain was very severe, disabling or intractable it would be permissible to administer a phenol block. He would not go so far as to say that Dr Hammann was wrong in adopting this procedure. Dr. Rose-Innes, who trained under Dr Hammann and saw him doing phenol blocks, said that Dr Hammann was an expert in this particular field and did phenol blocks well. He himself used phenol blocks and, although he did not do so for coccydinia, he said that it was an acceptable procedure which had been used by published authority of the highest repute. It was widely used for conditions which are not cancer but which produce severe intractable pain. By intractable pain he meant pain that did not respond to other forms of treatment, and he said that, provided one is dealing with a case of intractable pain, he would grant any competent surgeon the right to use it. Dr Mendelow's attitude was that he did not treat a condition if there was no discernible cause, and he would therefore not have done a block in the present case. He, however, regarded a phenol block as an acceptable, reasonable and a safe procedure and he would not deny any of his colleagues the right to use such a procedure in this condition. In support of his opinion he referred to several published articles on the subject. His view was that in respect of any pain, whether intractable or not, the crux of the matter is the doctor's assessment of how disabling the pain is to the patient and

whether it requires treatment, and the form of the treatment must then be with the doctor.

Watermeyer J said that in his view, Dr Mendelow's approach was the correct one, namely, that whether or not it should have been done depended upon Dr. Hammann's assessment of the degree and severity of the pain which he was being called upon to treat. He noted that it is a well recognised principle of South African law that in cases of this nature, viz. where there is a claim against a deceased estate, although the degree of proof required is no higher than in ordinary cases, the evidence of the plaintiff should be scrutinized with caution. Dr Hamman was not available to testify as to his assessment of the degree and severity of the pain from which Mrs Richter suffered. Watermeyer J observed that none of the expert witnesses went so far as to say that it would be negligent to administer a phenol block for coccygeal pain of a severe nature. The second plaintiff, Mrs Richter, was not prepared to accept Dr Butler's advice to persevere with conservative treatment and Watermeyer J commented that she was probably insistent that something had to be done about it. She had told Dr Hammann that she had had all sorts of treatment and must have told him that physiotherapy and cortisone injections had not helped. Hammann was an expert in this field and he had never before experienced from a unilateral block the unfortunate results which occurred in the present case. The court noted that all the neuro-surgeons agreed that the results in Mrs Richter's case were very unusual and most uncommon, and, in Dr. Rose-Innes' words, "they could not have been expected by any stretch of imagination".

Watermeyer J noted that the second plaintiff said that if she had been warned that there was any danger she would not have consented to undergo the operation. This was a new ground of negligence introduced for the first time when the particulars of claim were amended. Here, too, the court was entirely dependent upon the plaintiff's evidence which was subject to the same uncertainties and criticisms as had been mentioned earlier, more particularly because she conceded that there was a discussion between Dr. Hammann and herself about danger to a possible foetus and there was also a discussion about how long the effects of the phenol block would be likely to last. Watermeyer J said that the problem still arose as to whether in the circumstances of the present case Dr. Hammann was under a duty to warn, and if so whether a

failure to warn would constitute actionable negligence on his part. He said that the question of the duty of a medical practitioner to warn a patient of the possible dangers connected with an operation and in what circumstances such failure could constitute negligence, is a vexed question and there are few authorities on the subject. He referred to *dicta* in the cases of *Lymbery v Jefferies*[39] and *Esterhuizen v Administrator, Transvaal*[40]and then continued to observe that the present action was not one for assault. The allegation was that Dr Hammann was negligent in failing to warn the patient. Watermeyer J noted that doctor whose advice is sought about an operation to which certain dangers are attached - and there are dangers attached to most operations - is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient's interests to have it. He said that it may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is so, it seems in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem. In reaching a conclusion, said Watermeyer J, a court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do. The Court must make up its own mind but will be assisted in doing so by medical evidence. After examining the evidence Watermeyer J concluded that if Dr. Hammann did not mention the possibility of complications to the plaintiff he was not negligent in failing to do so. The plaintiff's claim was dismissed with costs on the grounds that she had failed to prove negligence on the part of Dr Hamman.

Discussion

The patient in this case seems to have been one of those unfortunate individuals who suffer from chronic pain, travel from one doctor to another trying to find immediate relief and are not happy to accept that at times, the more conservative route, although it may take a bit longer, is ultimately preferable. They require 'active' treatment of their condition. The court in this case had to consider whether the risks that materialised and which, on the basis of the expert evidence before it, was highly

39 *Lymbery* fn 33 *supra*
40 *Esterhuizen* fn 4 *supra*

remote, should have been mentioned to the plaintiff before the procedure was carried out. In this sense it was a case about informed consent and the lengths to which a provider is legally required to go in informing the patient before obtaining the required consent. It is of interest that the court in this case applied the standard of the reasonable doctor, a standard that was subsequently rejected by Ackermann J in the judgment in *Castell v de Greef* which put the standard of the reasonable patient decisively on the map. Although Watermeyer J indirectly considered the question of so-called therapeutic privilege it was not directly applicable in the present case because the remoteness of the risk seemed to be the main issue around which the case revolved. The evidence seemed to suggest that the consequences to the patient that had actually materialised were so remote as to be unforeseeable. In this event, it is submitted that even on the reasonable patient test, the doctor in this case would not have been negligent in failing to inform the patient of the risk since it was not a foreseeable one. The question of whether the procedure used by Dr Hamman was the appropriate one also seems to have been answered in the affirmative and the case indicates that there are many ways, in medical terms, of skinning a cat and that just because one doctor does it differently does not necessarily mean that he is wrong.

The question of the failure of a patient to take a provider's advice and the insistence of the former on less than optimal treatment is interesting in the context of this case. It may well be that Dr Hamman, although an expert at phenol blocks, may not have used them as a routine treatment of coccydinia and that it may have been at the patient's insistence that he decided to use this particular method of treatment despite the fact that other doctors had advised conservative treatment and Dr Hamman himself seems to have tried a number of options before he used the phenol block. At a broader level the question is to what extent a provider can be held liable for treatment that he knows is not the best option for the patient or that is contrary to his best advice although not necessarily contrary to medical practice generally. The issue of pain management is particularly significant in this context because there is usually no scientific way to measure a patient's subjective experience of pain. In fact the court recognised in *Hamman* that whether or not the treatment should have been given rested on the doctor's assessment of the degree of severity of the patient's pain. If a provider is of the view that a condition can be treated conservatively and that this is the best route for the patient to follow, but the patient insists on other more active treatment, it is

submitted that the maxim *volenti non fit injuria* comes into play and as long as the patient has given informed consent, the provider should not be held liable for any materialisation of the risks accepted by the patient. The patient's right to self determination means that he or she is free to make the wrong choices. However, if the patient is requesting treatment which is contrary to recognised medical practice or which the provider knows is likely to do more harm than good in the patient's circumstances, the provider may not necessarily be able to escape liability if he proceeds with the treatment. It is submitted that there are limits, in terms of public policy considerations, to what a patient can consent to even if it is informed consent[41]. A patient's right to self-determination is not absolute and must be balanced against the interests and *boni mo*res of society.

9.2.7 Blyth v van den Heever[42]

Facts

The facts appear from the judgment of Corbett JA as follows. At about 4.30 pm on Sunday 23 May 1971 the appellant (plaintiff below) sustained fractures of the bones of his right forearm (the radius and the ulna) as a result of a fall from his horse while playing polo. After receiving, at the polo field, first-aid in the form of the application of an L-splint to his arm and an injection, appellant was conveyed in a private motor vehicle to the provincial hospital at Ermelo, a distance of some 61 km. He arrived there at about 5.30 pm. The family doctor at the time was the respondent (defendant below). He was called to the hospital and saw the appellant at about 6 pm. Having examined the broken arm, respondent decided to perform a reduction of the fractures under general anaesthetic. Arrangements were made for an operating theatre to be made ready for this purpose at 8 pm that evening and for an anaesthetist to be available. At the appointed time the operation was performed. It ultimately took the form of an open reduction (i.e. a reduction involving a surgical incision in order to expose the fracture site) of both the radius and the ulna. In the case of the ulna the two

41 The defence of *volenti non fit injuria* has been held to fail where shunters were negligent in not warningthe driver of train in time to stop where a workmen's loader operating too close to the track (*Union National South British Insurance Co Ltd v South African Railways and Harbours* 1979 (1) SA 1 (A)); where it was the duty of a busdriver to look after the safety of his passengers and the busdriver knew that a passenger was standing in a dangerous place in front of an open door of the bus but failed to warn the passenger (*Fredericks v Shield Insurance Co Ltd* 1982 (2) SA 423 (A)). See also *Matthee and Another v Hatz* 1983 (2) SA 595 (W)

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

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

bone fragments were aligned and fixed in position by means of a metal plate. Finally the arm was encased - from approximately the middle of the upper arm to the base of the fingers - in a plaster cast.

The appellant remained in the Ermelo hospital from then until the following Saturday (29 May 1971), when he was moved to the Rand Clinic in Johannesburg. By that stage a massive sepsis had destroyed most of the muscle tissue in the extensor and flexor compartments of appellant's right forearm and also certain of the forearm nerves. On the Sunday (30 May) a specialist orthopaedic surgeon, Dr Boonzaaier, who had treated appellant on Friday 28 May, told the appellant's mother, Mrs M E Blyth (Mrs Blyth senior), that the appellant 'would be lucky if he retained 20 per cent use of his arm'. This prognosis proved to be unduly optimistic. Despite a week's treatment at the Rand Clinic, where appellant was attended by Dr Boonzaaier, the sepsis persisted. At the end of the week (i.e. on Saturday, 5 June) the appellant was allowed to go home. Thereafter he was seen once a fortnight by Dr Boonzaaier. There was, however, no material improvement in the condition of his arm. After he had seen two medical practitioners in Durban, appellant eventually consulted Prof Louis Solomon, Professor of Orthopaedic Surgery and Chief Orthopaedic Surgeon at the University of Witwatersrand. This was on 28 August 1971. Prof Solomon performed an operation on the arm on 2 September 1971 with a view to eliminating the infection. This was successful in that the infection cleared up after two or three weeks. Thereafter, a colleague of Prof Solomon, a Dr Biddulph, who specialises in hand surgery, attempted certain reconstructive surgery aimed at restoring to some extent the nerve function in the forearm and hand. The operation was performed in two stages on 26 October 1971 and 25 January 1972. Prof Solomon assisted at the first operation. These procedures produced very limited, if any, improvement in the condition of appellant's arm. Eventually the surgical wounds healed and the position became stabilized. At the time of the trial in the Court *a quo* the forearm had become reduced to what the trial Judge (Eloff J) described as 'a shrunken clawlike appendage of extremely limited functional value'. On 17 May 1974 appellant instituted action in the Transvaal Provincial Division against respondent, claiming damages in the sum of R70 941 and costs of suit. Shortly before the trial, which commenced on 21 March 1977, this claim was increased to R112 123,56. After a lengthy trial Eloff J granted

absolution from the instance with costs. The present appeal was against the whole of the trial Judge's judgment and order.

Judgment

Corbett JA observed that broadly speaking, the appellant's case against respondent was that in treating him for the broken arm the respondent acted negligently in that he failed to exercise the professional skill and diligence required of him, as a medical practitioner, in the particular circumstances of the case; that the respondent's negligence in this regard caused or materially contributed to the functional disability affecting the appellant's right arm and the pain and suffering which he had endured in regard thereto; and that the respondent was consequently obliged, in delict, to compensate the appellant in damages. In the appeal, the appellant's counsel confined his case, on the negligence issue, to certain aspects of the post-operative care and treatment of the appellant. In so circumscribing the issues appellant's counsel, said Corbett JA, exercised a wise discretion since a reading of the evidence showed that the other grounds were either not shown preponderantly to have constituted professional negligence or were not causally connected with the ultimate disaster which overtook appellant's right arm. According to Corbett JA the case resolved itself into three main questions: (i) what factually was the cause of the ultimate condition of the appellant's arm; (ii) did negligence on the part of the respondent cause or materially contribute to this condition in the sense that respondent by the exercise of reasonable professional care and skill could have prevented it from developing; and (iii) if liability on the part of respondent be established, what amount should be awarded to appellant by way of damages?

It was common cause that the appellant's forearm was invaded by a massive sepsis. The general consensus was that the micro-organisms which brought about the sepsis were probably introduced into the arm at the time of the operation on Sunday night and by reason of the surgical incisions then made. It was no part of the appellant's case that in so introducing the sources of the infection, or in failing to prevent their introduction, the respondent acted negligently. The sepsis must, therefore said Corbett JA, be regarded as a causal factor which is factually relevant but legally neutral. The appellant's case, however, broadly speaking, was that it was not sepsis alone, but

sepsis operating upon and in conjunction with a very serious ischemic condition in appellant's forearm that caused the eventual catastrophe. In outline, the theory was that the ischemic condition developed shortly after the operation, that it gained in intensity during Monday and Tuesday and that by about 6 pm on Tuesday irreversible damage on a large scale had been caused to muscle and nerve tissue in the appellant's forearm. This dead, or necrosed, tissue, together with damaged tissue at or near the fracture sites, was particularly vulnerable to the invading micro-organisms and formed a ready medium for the rapid and extensive spread of the infection. The respondent's case, on the other hand, was, broadly, that there was no large-scale ischemia, but that sepsis alone or sepsis operating initially upon the limited tissue necrosis at or near the fracture sites (the so-called 'limited tissue necrosis' theory) were the sole causes of the ultimate condition of appellant's arm. The court observed that 'ischemia' means a deficiency of blood in a particular part of the body due to a constriction or occlusion of the blood vessels supplying that part. The most important function of blood is to supply oxygen to the tissues. Tissues cannot survive without oxygen. Consequently a protracted ischemia can cause the death of tissue. There are basically two ways in which an ischemic condition of the muscles and nerves of the forearm can develop. The one is where an artery or major blood vessel serving the forearm becomes injured or constricted or occluded. The other is where a condition, referred to in evidence as a 'compartmental syndrome' develops. With regard to the latter the court observed that it appears from the literature on the subject that a Volkmann's contracture resulting from traumatic injury (such as a bone fracture) is most likely to develop in the lower leg or in the upper arm or upper forearm. Consequently medical practitioners treating, *inter alia*, fractures of the upper forearm must be on their guard against the possible development of an ischemic condition leading to a Volkmann's contracture. They must watch out for the signs and symptoms of an impending ischemia and, if these signs present themselves, take remedial action. The classical symptoms are summed up in what have been described as the 'five p's': pain, pallor, pulselessness, paralysis and para-anaesthesia (loss of sensation over and below the ischemic area). Depending on the type of ischemia involved, these symptoms may vary in their incidence and intensity. Thus, for example, the symptom of pulselessness may not present itself, initially at any rate and there are recorded instances of a Volkmann's contracture having developed without the pain symptom or in a relatively painless manner. The court noted that once the

threat of a Volkmann's contracture has been diagnosed or is suspected, remedial action must be taken. Since the ischemic condition in the affected limb is, in the case of a compartmental syndrome, the result of a pressure build-up in the forearm, the most important remedial action is to try to achieve a decompression. If the limb is encased in a circumferential plaster cast, then this must be split and, if necessary, removed. There was considerable debate between the experts as to the real extent to which a plaster cast may contribute to a compartmental syndrome, particularly where there is a padding of cottonwool between the plaster and the limb; but, whatever the decompressive effect of the removal may be, it is necessary that this should be done, firstly, in order to make a proper diagnosis and, secondly, as a prelude to more drastic action, if that should prove necessary. If the removal of the plaster, gentle massage and other treatment does not bring the necessary relief, then an operation known as a 'fasciotomy' must be performed. This involves, in the case of the forearm, a surgical splitting of the deep fascia down the length of the forearm in order to remove the compressive effect of this inelastic sleeve upon the tissue, blood vessels and interstitial fluids contained in the osteofascial compartments. Corbett JA observed that the evidence indicated that the build-up of an ischemic condition of this nature (i.e. the compartmental syndrome) may be very rapid or it may be a slow, insidious process. It starts with the tiny blood-vessels at the extremities of the vascular system (what one of the experts termed the 'vascular tree') and, as more and more blood-vessels become occluded, it works its way towards the larger blood-vessels and eventually spreads throughout the fascial compartment. It was the appellant's case, and the view of his experts, that the onset of the alleged ischemia was a fairly rapid one and that by 6 pm on Tuesday 25 May it had done its damage.

With regard to causation the court stated that in determining what in fact caused the virtual destruction of the appellant's arm, the court must make its finding upon a preponderance of probability. Certainty of diagnosis is not necessary. If it were, then, in a field so uncertain and controversial as the present one, a definitive finding would become an impossibility. Corbett JA stated that bearing in mind that in the appellant bore the burden of proof, the question was whether it was more probable than not that large-scale ischemia, coupled with sepsis, caused the damage[43]. After considering all

[43] See *Ocean Accident and Guarantee Corporation Ltd v Koch* 1963 (4) SA 147 (A) at 157

the evidence, he held that it was more probable than not that the appellant suffered a severe and generalised ischemia in his right forearm, that this ischemia so devitalised the muscle tissues of the forearm that it was possible for the staphylococcal infection to become a massive and invasive one and that as a result thereof there was a large-scale destruction of muscle and nerve tissue and ultimately a fairly typical Volkmann's contracture. This finding reversed that of the court *a quo*. The next question considered by the court was whether the eventual result was attributable to negligence on the part of the respondent.

Corbett JA observed that, applying the basic principles relating to delictual negligence which is causally linked to the damage suffered to the situation in the present case, the enquiry resolved itself into the following questions:

(i) Whether the reasonably skilled and careful medical practitioner in the position of the respondent would have realised that a serious ischemic condition was developing or threatening to develop in appellant's forearm and, if so, when he would reasonably have come to realise this.
(ii) Whether there was remedial action which could reasonably have been taken
(iii) Whether the same notional practitioner would have known of this remedial action and would have realised that it had to be taken.
(iv) Whether the remedial action, if taken when the need for it ought reasonably to have been realised, would have prevented the damage suffered by appellant.
(v) Whether respondent himself failed to take such remedial action.

With regard to (i) the court held that that the reasonably skilled and careful medical practitioner in the position of respondent would have been aware of the danger of an ischemic condition developing in the appellant's forearm. He would have known that this danger was a dual one, i.e. it could arise by reason of arterial occlusion or embarrassment or because of the development of a compartmental syndrome. With regard to (ii) and (iii) the court held that the very first step would be to remove the plaster or split it completely and expose the skin. This in itself had two advantages. If the plaster was constricting the arm, removal or splitting would bring relief. Secondly removal or splitting would enable the practitioner to examine the arm and to see what is occurring underneath all the dressings. The doctor would be able to see whether the arm itself appeared swollen or whether from the appearance of the skin there was

swelling and compression within the fascial compartments. Furthermore, the usual tests for ischemia, designed to detect the five p's and the passive extension test, would then be performed. Thereafter the patient's condition would be carefully watched and, if the adverse symptoms persisted, then the more drastic step of a fasciotomy would have to be considered, and, if necessary, performed. With regard to (iv) the court found that the evidence as a whole, established as a matter of probability that, had the respondent been alerted by his own observations to the danger of an impending ischemia on Monday morning, either when he saw appellant at 8 am or later in the morning when he was telephoned, and taken the appropriate remedial action then the severe and generalised ischemic condition with concomitant tissue necrosis would have been avoided. This would have prevented the *staphylococcus aureus* infection from spreading in the way in which it did. It would have been sealed off and localised by the body's natural defensive responses. The likelihood, therefore, was that there would have been no large-scale muscle destruction and no nerve lesion. The appellant might have had two unpleasant abscesses in the region of the surgical wounds, but there it would have ended. More probably than not the fractures would have healed satisfactorily and appellant would have regained the full use of his arm. With regard to question (v), the court found that it was clear that the requisite remedial action was not taken by respondent. This was partly because he did not diagnose an impending ischemia or suspect the possibility of one developing. In failing to do so, he was, therefore, negligent in that he failed to display the skill and care reasonably to be expected of him. Another reason, said the court, why he failed to make the appropriate diagnosis was because he did not maintain the necessary vigilance (he allowed 24 hours to elapse between visits during this vital period) and when he was telephoned by the sisters and told of their concern he did not go to see things for himself. Corbett JA said that this was the stage *par excellence* when he should have hurried to the hospital, removed the plaster and commenced the remedial procedures detailed above. In failing to do this and in particular in leaving the splitting of the plaster to the nursing staff he failed in his duty towards his patient and was negligent.

As regards damages Corbett JA observed that the practice of South African courts in assessing damages in a situation such as the present was well stated by Colman J in

Burger v Union National South British Insurance Co[44]. In this connection, observed Corbett JA, Colman J drew a distinction between causation and quantification and observed that it had never been the approach of the court, when faced with uncertainties in regard to the consequences of injury and the quantification of the loss suffered, to resolve these uncertainties by the application of the burden of proof. Although, as Colman J conceded, it is not always possible to distinguish clearly between causation and quantification in this sphere, Corbett JA agreed that this distinction underlies and justifies the general practice of taking into account certain future possibilities, which have not been shown to be probabilities, in computing prospective damages[45]. There was a possibility that the appellant may have to have his arm amputated although he was refusing to acknowledge this possibility at the time of the court case. Corbett JA noted that the appellant was a farmer and that whether he continued with his present disablement (with the possibility of slight improvement as a result of reconstructive surgery) or opted for amputation and an electronic arm, he would be severely handicapped in his day-to-day farming activities. In order to compensate for this he could be provided with a semi-skilled assistant to supplement this deficiency in his working effectiveness. For this aspect he held that an award of R7 500 would provide fair and adequate compensation. With regard to general damages for pain and suffering, permanent disability, disfigurement and loss of amenities, the court awarded R20 000 in damages saying that the pain and suffering attributable to the ischemia, the invasive sepsis, the virtual destruction of his forearm and the various remedial procedures which were attempted must have been very considerable. He noted that having a suppurating, septic arm for about four months must itself have been a very unpleasant experience and that the disability, which was the virtual loss of function of his right arm, was a most serious one. The appellant had faced his misfortune with fortitude and had shown a willing ingenuity in adapting to his handicap. Although right-handed, he had learnt to write with his left hand and also

---

44 *Burger* 1975 (4) SA 72 (W) at 75D – G where Colman J held that: 'A related aspect of the technique of assessing damages is this one; it is recognised as proper, in an appropriate case, to have regard to relevant events which may occur, or relevant conditions which may arise in the future. Even when it cannot be said on a preponderance of probability that they will occur or arise, justice may require that what is called a contingency allowance be made for a possibility of that kind. If, for example, there is acceptable evidence that there is a 30 per cent chance that an injury to a leg will lead to amputation, that possibility is not ignored because 30 per cent is less than 50 per cent and there is there fore no proved preponderance of probability that there will be an amputation. The contingency is allowed for by including in the damages a figure representing a percentage of that which would have been included if amputation had been a certainty. That is not a very satisfactory way of dealing with such difficulties, but no better way exists under our procedure. I would refer, in regard to this aspect of the matter, to the remarks of Wessels JA in *Van Oudtshoorn v Northern Assurance Co Ltd* 1963 (2) SA 642 (A) at 650 - 651.'

45 Corbett JA also referred to *Kwele v Rondalia Assurance Corporation of SA Ltd* 1976 (4) SA 149 (W) at 152H - 153A in this regard.

to play tennis left-handed, using the contracted right hand in some ingenious way to throw up the ball when serving. Nevertheless, there remained a disablement which adversely affected the sports and pastimes such as polo, golf, swimming, dancing, rowing, fishing and weight-lifting of which he was fond. It noted that he was also handicapped in his daily activities, eg dressing himself, bathing himself, cutting his food at table, playing with his young children and so on. Corbett J said that the state of the appellant's arm represented a very considerable disfigurement and noted that the appellant confessed that he was very self-conscious about it. No doubt, in the course of time, said Corbett JA, this feeling of self-consciousness would diminish, but it would probably never disappear entirely.

Discussion

The extensive and detailed factual analysis conducted by Corbett J in his judgment in this case is indicative of just how complex questions of causation in the health care context can become. The important point to note about this case is that it confirms the judgment in *Dube v Administrator Transvaal*[46], which also involved a Volkmann's contracture following a fractured arm, to the effect that once a provider takes on the treatment of a patient it is his responsibility to ensure that throughout the process the necessary precautions are taken to ensure a successful result. Included in this requirement is an awareness of complications that may foreseeably develop and the measures that must reasonably be taken to avoid them. One cannot fall back on the argument, for instance, that if left untreated the contracture would have developed anyway and that the medical intervention should not be regarded as a kind of *novus actus interveniens* because it does not interrupt the chain of causation started by the original accident. This kind of argument is only applicable in circumstances where the medical intervention was not negligently conducted and so is of no use to a provider as a defence to claims for medical negligence. If, but for the negligence of a provider, the patient would have received the proper medical care and treatment in the normal course of events, then the final state of the patient's health is causally attributable to the negligence of the provider in treating him.

---

46 *Dube v Admionistrator Trasnvaal* 1963 (4) SA 260 (W)

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Facts

The excipient claimed damages for negligent surgical operation to her right kidney carried out by the respondent, which caused the loss of her right kidney, pain, suffering, loss of amenities of life, anguish and misery, all of which caused her damages in the sum of $25 000 of which she claimed payment and costs of suit.

In her declaration, she stated that, on 26 September 1980, the defendant performed a surgical operation upon her right kidney and that he performed this operation negligently, because:

(a) there were no grounds or there were insufficient grounds for conducting the said surgical operation;

(b) during the course of the said surgical operation, the defendant injured her right kidney; and

(c) the defendant failed to remove, after the said surgical operation, a splint (or catheter) which had during the surgical operation been introduced by the defendant into her right ureter.

She averred that the result of the defendant's failure to remove the splint from her right ureter until 27 January 1981 was that she suffered a recurrent urinary infection of the bladder, pain and anxiety. She also averred that the negligent operation as a whole occasioned her pain and suffering and the injury to her right kidney resulted in its nephrosclerosis and its atrophy, requiring its surgical removal on 13 March 1984. She concluded that the injury and its consequences occasioned her pain, suffering, chronic illness, anxiety and a reduced expectation of life. Hence, she claimed specific damages in the sum of $2 500 and general damages in the sum of $22 500.

The respondent in response filed a special plea in bar under Rule 137 (1) (a) of the High Court Rules and pleaded that the excipient's claim had prescribed in terms of section 13 (1) of the Prescription Act 31 of 1975 because:

---

47 *Correira* 1986 (4) SA 60 (ZH)

(a) the date of the alleged negligence and surgical operation was 26 September 1980;

(b) the further allegation of negligence for failure to remove the splint was until 27 January 1981;

(c) the period of prescription in terms of s 14 (d) of the Prescription Act in respect of such claims is three years;

(d) in terms of s 15 (1) of the Act prescription began to run not later than 27 January 1981; and

(e) summons in this case was only served on 4 March 1985, more than three years after 27 January 1981.

Following the filing of the special plea in bar, the excipient requested further particulars under Rule 137 (1) (d) in the following matters:

(a) The dates on which the claims in the various paragraphs become due, and when did the excipient become aware of the identity of the defendant and the facts in the various paragraphs.

(b) Whether it was alleged that the excipient could have acquired knowledge of the facts from which the claim arises by exercising reasonable care? If so, then this was to be specified.

(c) Whether it was also alleged that the excipient could have acquired knowledge of such identity and of such facts by exercising reasonable care and if so these also were to be specified.

The respondent supplied the particulars regarding when the two claims became due, but with regard to the request on when the excipient became aware of the identity of the defendant and the facts, he stated that since the plaintiff's claim in this matter was based on a contract between her and the defendant, the particularity sought in respect of s 15 (3) of the Prescription Act was irrelevant. Accordingly the defendant declined to give such particularity.

As a result of this refusal by the respondent to produce the particulars, the excipient filed this exception to the special plea in bar denying that her claim in the declaration arose from contract as contemplated by s 15 (3) of the Prescription Act and that therefore as a matter of law the respondent was obliged in terms of s 15 (3) of the Act

to allege in raising prescription that the excipient became aware of the identity of the defendant and the facts from which the claim arose before 5 March 1982 and/or that the excipient could have acquired knowledge thereof by exercising reasonable care, that this he failed to do, and that the respondent's contention that her claim was based on contract between her and the respondent was argumentative, vague and embarrassing and did not arise from any allegation in the excipient's declaration. In the circumstances, she prayed that the respondent's special plea in bar be set aside with costs, alternatively that paras 1 (b) and (c) and 2 (b) and (c) of the defendant's particulars filed on 30 May 1985 be struck out with costs.

Counsel for the excipient stated that two issues were raised on the papers. First, whether the excipient had sued in tort or in contract and secondly, if the excipient had sued in tort, whether it was open to the defendant to assert by way of a special plea that the claim was founded on contract. He submitted that, the excipient sued in tort, not contract, because the summons was for 'damages for negligent surgical operation' and the declaration cited the respondent as a urologist, alleging that he performed a surgical operation upon the excipient and alleged negligence in performing the operation as there was insufficient grounds for it and the manner in which the respondent performed the operation. Nowhere, he said, did the excipient allege agreement express or implied, nor did she claim refund of any medical fees for breach of contract, pecuniary loss or loss of business income. Her claim was solely for injuries to her body and mental state. With regard to the second point, counsel for the excipient submitted that the defendant had not excepted to the claim as being bad in law on any contention that the plaintiff could not claim against a surgeon or other professional person in delict or tort.

Counsel for the excipient stated that the main issue which arose was whether a surgeon who was sued for physical injuries inflicted in the course of an operation performed by him could be sued only in contract. If he could be sued either in contract or in delict, it followed that the excipient could elect to sue him in tort as she had done in this case because in law a claim always lies in tort against a person who has by want of reasonable care caused another physical injury, i.e. injury to person or property, subject only to certain limits imposed by social considerations.

Counsel for the respondent argued that the excipient's action was in contract because, in para 3 of her declaration, she alleged that services were rendered to her by the respondent in terms of a contract and that in any case the relationship between a doctor and patient is usually one in contract and that, in order to fix liability in delict, the court would have to be persuaded that the decision in *Lillicrap, Wassenaar & Partners v Pilkington Brothers (SA) (Pty) Ltd* [48] was wrongly decided. He also argued as, a corollary to the first submission, that as the action was founded on contract and under the exception provided by section 15 (3) of the Prescription Act, the respondent was not required to state when the creditor became aware of the identity of the debtor and of the facts from which the debt arose.

Judgment

Mfalila J said that the first question to consider was whether the excipient alleged in her declaration that the services were rendered to her by the respondent in terms of a contract. He found that she had not and that the paragraph on which counsel for the respondent had relied was simply an explanation of her claim in the summons for "damages for a negligent operation to her right kidney carried out by the defendant...".

Secondly, the court looked at whether it was correct to say that a doctor was not liable to his patient outside of a contractual relationship and that therefore there was no liability in delict within the relationship of doctor and patient. Mfalila J said that he did not think one could seriously quarrel with counsel for the respondent's assertion that "the relationship between a doctor and patient is usually one of contract" without statistics on the relative numbers of patients who enter into contracts with their doctors and those who simply consent to be treated relying on the professional expertise of the doctor. But, said the court, even if it were correct to say that the relationship between a doctor and patient is usually one in contract, this is not the same thing as saying that a contractual relationship is the only one that can subsist between a doctor and patient. Mfalila J noted that Strauss, *'Doctor, Patient and the*

[48] *Lillicrap* 1985 (1) SA 475 (A)

Law[49] quoted by counsel for the respondent, made no such point on the relevant pages cited. Indeed, said the judge, he would have been very surprised if Strauss had made such a suggestion in Section I of the book dealing with contractual obligations of the doctor when in Part XI of the book he discussed the liability of doctors for medical negligence.

The court noted the words of Lord Nathan[50] to the effect that irrespective of the existence of a contract there is a legal obligation to take due and proper care and that this duty co-exists with any contractual arrangements between the provider and the patient. Mfalila J came to the conclusion that as between a doctor and patient there can exist both contractual and delictual liabilities. The court considered the judgment in *Lillicrap* and noted the *dicta* of Grosskopf AJA in that case who recognised that the "present case thus raised fundamental questions relating to delictual liability, and more particularly, its relationship with the liability for breach of contract" and who stated that-

"even if a breach of contract should properly be classified as a form of delict, that would not alter its essential characteristics or eliminate the differences which exist between the action for damages arising *ex contractu* and liability pursuant to the extended Aquilian action which the respondent has sought to invoke in the present case"[51].

---

49 Strauss fn 29 *supra*

50 In 'Medical Negligence' at p15 where he states: "In the great majority of cases the duty owed by a medical man or a medical institution towards the patient is the same whether there exists a contract between them or not. Where there is no such contract, a duty arises by reason of the assumption of responsibility for the care of the patient; where there is such a contract, this duty in tort exists side by side with a similar duty arising out of the contract. But the implied contractual duty is normally the same as that which exists apart from contract."

51 Mfalila J quoted the following passage from the judgment in *Lillicrap* at 496D - H, stating that it dispels any notion that there can be no delictual liability where there is a contractual relationship between the parties: "In the present case it is common cause that the damages which the respondent is claiming pursuant to the Aquilian action could, in so far as they arose before the assignment of the contract to Salanc, have been claimed on the basis of breach of contract. The respondent's contention is that in the circumstances of the present case the facts gave rise to both causes of action. In principle there would be no objection in our law to such a situation. Roman law recognised the possibility of a *concursus actionum*, i.e. the possibility that different actions could arise from the same set of facts. More particularly, the facts giving rise to a claim for damages under the *lex Aquilia* could overlap with those founding an action under certain types of contract such as deposit, *commodatum*, lease, partnership, pledge etc. In such a case a plaintiff was in general entitled to elect which *actio* to employ... In modern South African law, we are of course no longer bound by the formal *actiones* of Roman law, but our law also acknowledges that the same facts may give rise to a claim for damages *ex delicto* as well as one *ex contractu*, and allows the plaintiff to choose which he wishes to pursue... The mere fact that the respondent might have framed his action in contact therefore does not *per se* debar him from claiming in delict. All that he need show is that the facts pleaded establish a course of action in delict. That the relevant facts may have been pleaded in a different manner so as to raise a claim for contractual damages is in principle irrelevant. The fundamental question for decision is accordingly whether the respondent has alleged sufficient facts to constitute a cause of action for damages in delict. In the present case we are concerned with a delictual claim for pecuniary loss, and, as mentioned above, it is common cause that the claim was founded on the principles of the extended Aquilian action. It is trite law that, to succeed in such a claim, a plaintiff must allege and prove that the defendant has been guilty of conduct which is both wrongful and culpable; and which caused patrimonial loss to the plaintiff... What has been placed in issue by the appellant is whether, on the facts pleaded, the appellant's conduct was wrongful for purposes of delictual liability and whether the damages alleged to have been suffered, are recoverable in a delictual action."

Mfalila J observed that the court in *Lillicrap* was faced with the question whether to extend Aquilian liability to an action for breach of contract. Although the court noted that "in our law Aquilian liability has long outgrown its earlier limitation to damages arising from physical damage or personal injury" and has been extended to cover negligent misstatements which cause pure financial loss, it remarked that there was no authority in Roman or Roman-Dutch law for the proposition that the breach of such a contractual duty is a wrongful act for the purposes of Aquilian liability. However, said Mfalila J the situation is different in the case of a *concursus actionum* because here the actions of the defendant satisfy the independent requirements of both a contractual and an Aquilian action. Such was the position in the case of *Van Wyk v Lewis*[52] because, independently of contract which existed, Dr Lewis would have been liable to his patient for professional negligence. On those considerations the Court held that "our law adopts a conservative approach to the extension of remedies under the *lex Aquilia*", and that "it would accordingly be breaking fresh ground if it were to recognise the respondent's cause of action as valid".

The court, referring to the dictum in *Lillicrap* to the effect that policy considerations did not require that delictual liability be imposed for negligent breach of contract of professional employment, stated that the pronouncements make it quite clear that if the respondent had satisfied the independent requirements of both a contractual and an Aquilian action, the court would have allowed the action and dismissed the exception as the court *a quo* had done. But the court of appeal found that the respondent had failed to satisfy in its pleadings the requirement for an Aquilian action when it refused to extend further the basis for such an action. The court held that in the present case, even if it were to find that there was a contract between the parties, it would find it no bar, as it was found in the *Van Wyk* case, to the excipient founding her action against the respondent in delict because independently of any contract, he owed her a duty of care when performing the surgical operation upon her, to perform it with such professional skill as to avoid injuring her which she alleged he did. In her summons, she alleged both the duty to take care and a breach of that duty.

---

52 *Van Wyk* fn 3 *supra*

Commenting on the *obiter dictum* by Innes CJ in the *Van Wyk* case that the delictual duty arose from the contract between the parties, Grosskopf AJA stated as follows at 502E - F:

"This interpretation (which he had just propounded) seems probable if one has regard to the unlikelihood that Innes CJ would have intended to suggest that a medical doctor could not be delictually liable for his negligence unless there was a contractual relationship between him and his patient."

The court observed that this statement put beyond doubt that the *Lillicrap* case made no decision along the lines suggested by Mr De Bourbon and that by fixing delictual liability on the respondent, far from suggesting that that case was wrongly decided, affirmed its correctness. To put the matter beyond controversy, said the court, Boberg, in his book *The Law of Delict*, opens his first chapter on the "Nature and Basis of Delictual Liability" with the following words based on the decision in the Lillicrap case:

"A delict is a civil wrong. It is an infringement of another's interests that is wrongful irrespective of any prior contractual undertaking to refrain from it - though there may also be one. It entitles the injured party to claim compensation in civil proceedings - though criminal proceedings aimed at punishing the wrongdoer may also ensue. A single act may arise to give both delictual and contractual, or delictual and criminal liability. The existence of concurrent contractual liability is no bar to an action in delict, provided that the requirements of delictual liability are also satisfied."

For the these reasons said Mfalilala J, he was satisfied that the excipient's claim against the respondent is properly based on delict or tort, that therefore the provisions of s 15 (3) of the Prescription Act ddi not apply and that the respondent was bound to furnish the information required by the excipient.

Discussion

The courts have shown a notable predilection when faced with a claim which can be adjudicated on the basis of both the law of delict and of contract to deal with it on the basis of the former. This is somewhat surprising given the fact that it is generally easier in terms of the burden of proof to show breach of contract than to show negligence in the delictual context. Perhaps the choice of the courts in giving judgment to reason in terms of the law of delict is because negligence has not in these

cases been that difficult to establish and according to Neethling, Potgieter and Visser[53] there is no fundamental difference between a delict and a breach of contract. The injured party can choose to act on the one or the other. They also point out that one and the same act can lead to the liability of the perpetrator both *ex contractu* and *ex delicto*. It is submitted that the courts may, for public policy reasons, also choose to focus on the claim based in delict in order to highlight what is in effect a civil wrongdoing and to emphasise the fact that the existence of a contract is unnecessary in such cases. In doing so, the emphasis of the judgment is subtly shifted from a purely business issue to a moral issue. The judgment in *Lillicrap* led to a fair amount of debate and criticism of the court's failure to allow the claim in delict[54]. However it still stands and, as the court pointed out in *Correira*, although the same action can 'give rise to claims in both contract and delict, each claim must stand on its own two feet independently of the other.

9.2.9 Clarke v Hurst NO And Others [55]

Facts

On 30 July 1988 and while undergoing epidural treatment, Frederick Cyril Clarke ('the patient') suffered a sudden drop in blood pressure and he went into cardiac arrest. His heartbeat and breathing ceased. Resuscitative measures were instituted but by the time that his heartbeat and breathing were restored, he had suffered serious and irreversible brain damage due to prolonged deprivation of oxygen to the brain (cerebral anoxia). He became deeply comatose and remained in that condition ever since. At the time the case was heard, the patient's swallowing mechanism was not functioning and consequently, even if he had been conscious, he would not have been able to ingest food in the natural way. The patient was fed artificially by means of a naso-gastric tube. Through this tube he was fed a ready made powder diluted with water. The powder provided all the patient's nutritional needs, while the water provided the hydration necessary for the maintenance of life. Food was digested

53 Neethling J, Potgieter JM and Visser PJ *The Law of Delict* at p 265. They note that the action for pain and suffering and the contractual action concur in circumstances where breach of contract also results in a wrongful and culpable infringement of the physical-mental integrity of the wronged contracting party. See also Claassen and Verschoor fn 2 *supra* at p 118

54 See Boberg fn 20 *supra* for a summary of these criticisms

55 *Clarke* 1992 (4) SA 630 (D)

naturally and the bowels were evacuated by involuntary reflex. There was a tendency to constipation and when this occurred suppositories were administered or manual evacuation was undertaken. The discharge of urine occurred in the normal manner but because it was involuntary, the urinary discharge was administered by a Paul's tube in order to keep the patient dry.

Because of the patient's inability to swallow, nasal secretions tended to flow down his trachea into his lungs. In order to maintain respiration unimpeded and to prevent infection, excess secretions were removed by suction several times a day. A plastic tube passed through a tracheotomy opening in the trachea into the patient's lungs. A suction machine was used to expel the excess fluid from the lungs. The patient was in what is commonly known as a persistent vegetative state. There was no prospect of any improvement in his condition and no possibility of recovery. The applicant, the patient's wife, applied to be appointed as *curatrix* to the patient's person with powers in that capacity to:

(1) agree to or withhold agreement to any medical or surgical treatment for the patient;

(2) authorise the discontinuance of any treatment to which the patient was subjected, or to which the patient may in future be subjected, including the discontinuance of any naso-gastric or other non-natural feeding regime or like regime for the hydration of the patient;

(3) act as set forth in paras (1) and (2) above notwithstanding that the implementation of her decisions may hasten the death of the patient.

In her founding affidavit the applicant had expressed it as her intention, if the application should be granted, to have the tube removed which was introduced into the patient's stomach to provide for his body's nutritional requirements. In effect what the applicant intended doing is to put an end to the artificial feeding regime whereby the patient obtained the necessary sustenance for his bodily functions. The applicant expressed herself as follows:

"If the order is granted I will consult with the medical practitioners with whom my husband will be in custody at the time and give such directions as will ensure that any physical distress which accompanies the removal of the tube is minimised; that being necessary, as I understand it, to preserve the dignity of the relationship between the attending medical staff

and my husband and to alleviate the stress on family members. I am of course mindful of the fact that my husband's death will follow the removal of the tube from his stomach. However, I respectfully submit that the removal of the tube will not cause his death. In my respectful submission what will cause my husband's death is the cardiac arrest that occurred on 30 July 1988. Notwithstanding their best efforts and intentions, all that the various medical attendants have been able to do is to suspend the process of death. They did not save my husband's life."

The applicant made it clear that the effect of stopping the artificial feeding regime would be to terminate the present 'suspension of the process of death' of the patient by starving the body of its nutritional needs. The application was supported by the patient's nearest relatives - his two sisters and his four children - all of whom were majors.

Judgment

The court noted the following concerning the patient. He was born on 22 March 1925 and was therefore in his 68th year. He was a qualified medical practitioner and at the time when he suffered the cardiac arrest he was still actively conducting a medical practice. From 1977 to 1986 the patient had been a member of the then Natal Provincial Council and from 1981 to June 1986 he had been a member of the Executive Committee of the Council, responsible for Hospital Services. The patient was a life member of the SA Voluntary Euthanasia Society. He had signed a document headed 'A Living Will' directed to his family, his physician and to any hospital and which read:

'If there is no reasonable expectation of my recovery from extreme physical or mental disability . . . I direct that I be allowed to die and not be kept alive by artificial means and heroic measures. I ask that medication be mercifully administered to me for terminal suffering even though this may shorten my remaining life. I hope that you who care for me will feel morally bound to act in accordance with this urgent request.'

During his active life the patient held strong views on the individual's right to die with dignity when living has ceased to be worthwhile and when there is no hope of improvement or recovery. In a public speech delivered in 1983 he said:

'I feel sure that the general public gets a certain degree of satisfaction in knowing that if they, by a stroke of misfortune, become cabbages or suffer prolonged and intractable pain where a successful outcome is impossible, no valiant and fruitless endeavours will be instituted by the medical team to prolong intense suffering and anguish and to, in fact, prolong death.'

These statements, said the court, undoubtedly stemmed from a settled, informed and firmly held conviction on the patient's part that should he ever be in the condition in which he has been since the cardiac arrest, no effort should be made to sustain his life by artificial means but that he should be allowed to die. In her application the applicant cited as first and second respondents, the senior medical superintendent and chief nursing services manager at Addington Hospital, where the patient was being cared for. As third respondent she cited the Attorney-General for Natal in his capacity as the prosecuting authority in the province. A *curator ad litem* was appointed to represent the patient's interests.

The third respondent, the Attorney-General, opposed the application on a number of grounds. He filed an affidavit in which he said that he was not prepared to undertake in advance not to prosecute should steps be taken to terminate the patient's life and that he was not prepared to declare in advance what his decision would be in the event of such steps being taken. He said that in view of his opposition to the granting of the order, the court did not have the power to 'tie his hands in the event of the contemplated termination of the patient's life' and that even if the Court did have the power it should refrain from exercising it in this case. Counsel who appeared on behalf of the Attorney-General submitted that despite the form which the applicant's order prayed for took, she was in effect asking for an order declaring that she would not be acting unlawfully if, in her capacity as *curatrix*, she were to withhold her agreement to the giving of medical and surgical treatment to the patient or if she were to authorise the discontinuance of artificial life-sustaining measures such as naso-gastric feeding, even though the discontinuance of such measures or the withholding of such treatment would result in the termination of the patient's life. The court concurred with this submission. It said that admittedly the order which was sought was not couched in the form of a declaratory order but took the form of an order conferring on the applicant, as *curatrix* to the person of the patient, certain powers (which have been set out at the beginning of the judgment). However, despite the form of the order, it was implicit in it that the applicant was asking the court to declare that she would not be acting unlawfully if she were to exercise those powers. The court said that if, in exercising the powers which she was asking for she would be acting unlawfully, the court would be exceeding its competence if it were to grant to her those powers. No court would be competent to sanction the commission of a

crime or a wrongful act. In essence, therefore, what the applicant was asking for was an order declaring that if she were to take the steps envisaged by her and if as a result of the taking of those steps the life of the patient were to terminate, she would nonetheless not be acting unlawfully.

Building on his submission that what the applicant sought was a declaratory order, counsel submitted that the court should refrain from making a declaratory order which would anticipate facts which have yet to come about which would pre-empt the authority of the Attorney-General to decide in due course whether to prosecute and which would render nugatory the provisions of the Inquests Act[56].

Thirion J noted that in *British Chemicals and Biologicals (SA) (Pty) Ltd v South African Pharmacy Board*[57] the fact that the applicant's right to relief depended on the interpretation to be placed on a piece of legislation which defines a crime, was held to be no bar to the making of a declaratory order sought for the express purpose of ensuring the applicant against a successful prosecution, despite the fact that the Attorney-General had not been made a party to the proceedings[58]. Thirion J said that this decision was authority for saying that the Court may in an appropriate case and despite the opposition of the Attorney-General, exercise its discretion in favour of declaring whether the adoption by an applicant of a certain course of conduct would constitute a crime. He said the Attorney-General's opposition in the present case to the proposed order was based on the misconception that in granting the order the Court would interfere with the absolute discretion vested in the Attorney-General with regard to criminal prosecutions and would be condoning the commission of a crime. That was not what was envisaged. The Court would only grant the order if on facts which are beyond dispute there was no reasonable possibility that the applicant, in acting on it, would commit a crime against the patient.

---

56 Inquests Act No 58 of 1959

57 *British Chemicals* 1955 (1) SA 184 (A)

58 Greenberg JA said at p 192: "The main grounds advanced in this Court on behalf of the respondent for the contention that the application was premature were that no substantive application had been made by the appellant to the respondent for any procedural step by the latter, that the appellant was in fact seeking a declaration which would ensure it against successful prosecution under s 76bis and that in any event an order of this kind should not be granted unless the Attorney-General is made a party to the proceedings. In *Attorney-General of Natal v Johnstone & Co Ltd* 1946 AD 256, the competency of the Court to grant a declaratory order that would have the effect of ensuring an applicant against successful prosecution was recognised; in that case the Attorney-General was a party to the proceedings but what was said (at 260-2) shows that this factor is not an essential one. In civil proceedings to which the Attorney-General is not a party the fact that the claimant's right to relief depends on the interpretation to be placed on a piece of legislation that defines a crime is no bar to a decision as to whether a certain course of conduct constitutes a contravention of that legislation. As regards the exercise of discretion conferred on the Court by s 102 of Act 46 of 1935, I see no ground for questioning its exercise by the learned Judge *a quo* in entertaining the application."

Thirion J said that in his view this is a proper case for the exercise of the Court's discretion. The applicant, he said, faced an agonising decision. She had a right in the circumstances to know whether in doing what she contemplated she would be transgressing the law. He pointed out that there was no case which could serve as guidance to her. She was emotionally involved. He said it was but right that the decision should be taken by the court, which can view the evidence dispassionately and objectively. In those circumstances the applicant was entitled to have the legal position determined by the Court. The *curator ad litem* supported the application. His reasoning was expressed thus: An adult of full legal competence has, while of sound mind, an absolute right to the security and integrity of his body. In the exercise of that right he is entitled to refuse to undergo medical treatment, irrespective of whether such refusal would lead to his death. Where, as in the present case, such a person, while he is of sound mind, has directed that if he should lapse into a persistent vegetative state with no prospect of recovery, he should be allowed to die and that he should not be kept alive by artificial means, then if he does lapse into such a state, there is no reason why a curator appointed to his person should not have the power to give effect to his direction. After examining three American cases which were cited in support of the application Thirion J said that he did not think that the approach adopted in these cases could be invoked in South African law to provide an answer to the question whether, were the applicant to discontinue the naso-gastric feeding of the patient, her conduct would be unlawful and whether, were he to die, she would be criminally liable for his death.

He held that the fallacy in counsel's argument lay in the fact that in South African law the *curator personae* is not a mere agent to give effect to directions given by the patient while he was competent to do so. The *curator personae* is at all times under a duty to act in the best interests of the patient and not necessarily in accordance with the wishes of the patient; the well-being of the patient being the paramount consideration. In South African law, the court would not simply weigh the patient's interest in freedom from non-consensual invasion of his bodily integrity against the interest of the state in preserving life or the belief in the sanctity of human life; nor would it necessarily hold that the individual's right to self-determination and privacy always outweighs society's interest in the preservation of life. Furthermore, said

Thirion J in South African law a person who assists another to commit suicide may, depending on the circumstances of the particular case, be guilty of murder or culpable homicide.[59] Referring to the American case of *Karen Quinlan*[60] Thirion J pointed out that the conclusion that the killing would not be unlawful was rested in part on the fact that the patient's death would result from the exercise of her constitutional rights to privacy and self-determination and would therefore be protected from criminal prosecution. He said that such an approach would not be open to the court in South African law. The issues in the present application, he said, could only be approached after a thorough evaluation of the patient's physical and neurological deficits and the extent of the biological and intellectual life which still remained to him. The specialist physicians and neurologists who examined the patient were in agreement that he was in a persistent vegetative state because of the extensive damage to the cortex - that part of the brain which is responsible for intellectual function and cognitive awareness. They also agreed that the damage was irreversible and that no improvement was possible.

Thirion J observed that the term 'persistent vegetative state' seemed to have been created by Dr Fred Plum, professor and chairman of the Department of Neurology at Cornell University and a world-renowned neurologist. He said it describes a neurological condition where the subject retains the capacity to maintain the vegetative part of neurological function but has no cognitive function. In such a state the body functions entirely in terms of its internal controls. It maintains digestive activity, the reflex activity of muscles and nerves for low level and primitive conditioned responses to stimuli, blood circulation, respiration and certain other biological functions but there is no behavioural evidence of either self-awareness or awareness of the surroundings in a learned manner. He noted that Steadman's Medical Dictionary defines 'vegetative' as functioning involuntarily or unconsciously after the assumed manner of vegetable life. Thirion J said that it seemed that the term 'persistent vegetative state' describes not a distinct condition but rather a range of chronically persistent neurological defects which are irreversible; with no cognitive or intellectual function and no self-awareness or awareness of the surroundings and no purposive bodily movement. He reviewed the evidence as to the patient's state noting

---

59 *Ex parte Minister van Justisie: In re S v Grotjohn* 1970 (2) SA 355 (A).

60 *Quinlan* 70 NJ 10; 355 A 2d 647 (NJ 1976)

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

that, the patient's biological life was stable, despite the extensive brain damage, because those parts of the brain-stem necessary for the functioning of that part of the autonomic nervous system which controls the essential organs, were operating satisfactorily. The swallowing reflex had, however, been damaged. Although swallowing can be induced or willed by the upper brain, it is a mechanism controlled by the brainstem. The court said that in order to assess what remained of the patient's human life, i.e. his cognitive or intellectual life, one had to examine the functioning of the upper sections of the brain (cortical function). Thirion J further observed that awareness is the ability of a person to perceive any aspect of the environment. In an unconscious patient this would be tested by applying some external stimulus and observing whether there is a response. He noted that Mr Staub performed several such tests on the patient. In some cases there were responses to the external stimuli. Those were the results of the auditory stimulation test, test of sensation of the face, reactions of pupils, painful stimulation of the limbs and forehead. All these responses, according to Mr Staub, may be mediated through the brain-stem or spinal cord and therefore did not prove that the patient was aware of his external environment at any level. In order to prove clinically that the patient was aware of the stimuli one would have to elicit a response from him that was not possibly mediated at brain-stem level but rather at cortical level. No such response could be obtained from the patient. Thirion J said that he was impressed by the care and caution with which Mr Staub performed his examination of the patient and with the guarded yet precise manner in which he has expressed and motivated his opinions. He accepted his conclusions and his assessment of the patient's condition. Thirion J summed up the patient's physical condition and then went on to examine the effects of the removal of the naso-gastric feeding tube. He noted that the discontinuance of the naso-gastric feeding and any other form of nourishment was bound to lead to the termination of such life as the patient still had. The period which it would take for the patient to die after the administration of nourishment had ceased was somewhat unpredictable. If the potassium levels were to suddenly rise considerably the patient could suffer a cardiac arrest. If this did not happen the patient would simply 'fade'. He would be totally unaware of what was happening. He would not register anything at all. His blood pressure would drop and his breathing would slow down until cardiac standstill occurred. There would be no dramatic or sudden death. Quiet, shallow breathing would simply turn into no breathing at all and life would be extinguished. This would

occur within two or three weeks after nourishment had ceased to be administered. The court said that there could be no doubt that the discontinuance of feeding would accelerate the patient's death unless some other cause were to intervene to kill him before then.

Counsel who appeared for the Attorney-General submitted that:

(i) any act which hastens a person's death is a cause of it, even though at the time of the commission of the act which results in his death he may already have been mortally injured or may already have been suffering from some terminal condition[61];

(ii) if a killing is intentional it is none the less murder, even though the killer may not have harboured any evil motive[62];

(iii) even an omission to act, if the omission results in the victim's death, would attract liability on the part of the non-doer, if he was under a legal duty to act so as to prevent the victim's death;

(iv) consequently in the instant case, if the applicant were to discontinue the naso-gastric feeding and the patient's death were to be accelerated or hastened thereby, the applicant's conduct would probably be unlawful.

Counsel's argument, said Thirion J, amounted to this: The discontinuance of the artificial feeding would hasten the patient's death and would thus be a cause of it and, as the applicant foresaw death as a probable result of the discontinuance of the artificial feeding, she would in law be liable for having unlawfully killed the patient.

According to Thirion J, on counsel's argument the wrongfulness of applicant's conduct would *prima facie* be inferred from the fact that it would prima facie be an invasion of the patient's subjective right to bodily integrity and an assault, and as her conduct would not be justifiable in law on any of the grounds of justification it would be stamped as unlawful. He said that the fallacy in counsel's argument lay in the fact that it assumed that conduct which is *prima facie* unlawful can in law only be justified under one or other of the stereotyped categories of grounds of justification such as self-defence, consent, necessity, etc. There is, however, no *numerus clausus* of

61 *R v Makali* 1950 (1) SA 340 (N)

62 *S v Hartmann* 1975 (3) SA 532 (C); *S v De Bellocq* 1975 (3) SA 538 (T)

grounds of justification. The stereotyped grounds of justification are specific grounds of justification of otherwise wrongful conduct which with the passage of time have become crystallised, with their own rules limiting the scope of their application. Wrongfulness is, however, a distinct and generally applicable element of delictual as well as criminal liability in the common law. In a case such as the present one has to examine the concept of wrongfulness itself in order to determine whether the conduct complained of falls within its limits[63]. Thirion J pointed out that, writing on the requirements for delictual liability, Van der Walt[64] emphasises that the element of wrongfulness constitutes the fundamental requisite for delictual liability. He defines the criteria for the determination of wrongfulness as follows:

'Conduct is wrongful if it either infringes a legally recognised right of the plaintiff or constitutes the breach of a legal duty owed by the defendant to the plaintiff. . . . The inquiry is concerned with whether the infringement of the plaintiff's interest was in the particular circumstances objectively unjustifiable. In order to determine this, account must be taken of the particular conflicting interests of the parties, the parties' relation to each other, the particular circumstances of the case, and any appropriate considerations of social policy.'

According to Van der Walt, conduct infringes a subjective right if it unjustifiably disturbs or interferes with the holder's capacities of disposal, use and enjoyment in regard to the object of the right. Whether a particular interference can be regarded as unjustifiable depends on the application of 'the general criterion of boni mores, the prevailing conceptions in a particular community at a given time, or the legal convictions of the community. The *boni mores* as a legal standard looks at the reasonableness of the defendant's conduct in the particular instance.'[65] Thirion J also

---

63 He pointed out that Grotius *Inleidinge* 3.32.3, 5 defines delict as 'een doen ofte laten zijnde uit zich zelve ofte door eenige wet ongeoorloft' and adds that 'uit zich zelve' is delictual 'alles wes strijdende is met de redelickheid, die aengewezen ende bekrachtigt werd door het aengheboren recht' (whatever is contrary to reason as indicated and confirmed by natural law – Maasdorp's translation). This formulation, said Thirion J, comes close to the statement of Mostert J in *Universiteit van Pretoria v Tommy Meyer Films (Edms) Bpk* 1977 (4) SA 376 (T) at 387C: "Onregmatigheid word basies aan die hand van die *boni mores* bepaal. Deur die maatstaf van die 'regsoortuiging van die gemeenskap' (sien *Ewels* se saak *supra)* toe te pas, verkry die regstelsel die voordeel van die wisselwerking tussen die ethos en geregtelike voorbeeld, en 'n soepelheid wat by meer presedentgebonde stelsels ontbreek."

64 *Law of South Africa* vol 8 para 20 at p 21 Joubert (ed)

65 Thirion J observed that "the writers are in agreement that considerations of social policy and the *boni mores* play a part in determining whether conduct is wrongful. Boberg *The Law of Delict* at 33 says: 'At the root of each of these crystallised categories of wrongfulness lies a value judgment based on considerations of morality and policy - a balancing of interests followed by the law's decision to protect one kind of interest against one kind of invasion and not another.' Van der Merwe and Olivier *Die Onregmatige Daad in die Suid-Afrikaanse* Reg 6th ed at 58 advocate the use of the criterion of reasonableness according to society's conception of what is just, for the determination of wrongfulness. 'Voortdurend moet in die privaatreg 'n belange-afweging tussen persone plaasvind aan die hand van die redelikheid. Die redelikheidsmaatstaf, of sosiaaladekwant soos dit soms genoem word, is 'n objektiewe maatstaf. Hier word eenvoudig met die algemene regsgevoel van die gemeenskap gewerk. Sosiaal adekwaat of redelik is 'n handeling gevolglik as dit volgens die regsgevoel van die gemeenskap regmatig is. Neethling, Potgieter and Visser *Deliktereg* at 29 also stress the requisite of reasonableness in determining what is wrongful: 'Die algemene norm of maatstaf waarvolgens vasgestel word of 'n belange-aantasting ongeoorloof is al dan nie is die regsopvattings van die gemeenskap: die *boni mores*. Die boni mores toets is 'n objektiewe redelikheidsmaatstaf. Die kernvraag is of die dader die benadeelde se belange in die lig

referred to the observation of Rumpff CJ in *Minister van Polisie v Ewels*[66] where, dealing with liability for an omission, the Chief Justice said that it would appear that the stage of development in our law has been reached where an omission is regarded as wrongful conduct also where the circumstances of the particular case are such that the omission not only evokes moral indignation but also that the legal convictions of society ('die regsoortuiging van die gemeenskap') demand that the omission be regarded as wrongful. Thirion J said he thought that that the converse would also hold true. If the legal convictions of society do not require that an omission (or for that matter a positive act) be regarded as wrongful, it would not be wrongful in law. Wrongfulness is tested according to society's legal, as opposed to its moral, convictions but at the same time morality plays a role in shaping society's legal convictions. He held that if it is accepted, as he though it should be, that law is but a translation of society's fundamental values into policies and prescripts for regulating its members' conduct, then the court, when it determines the limits of such a basic legal concept as wrongfulness, has to have regard to the prevailing values of society. Thirion J said he could see no reason why the concept of wrongfulness in criminal law should have a content different from what it has in delict.

In the court's view, the decision whether the discontinuance of the artificial nutritioning of the patient and his resultant death would be wrongful, depended on whether, judged by the legal convictions of society, its *boni mores*, it would be reasonable to discontinue the artificial nutritioning of the patient. The decision of that issue, it said, depends on the quality of the life which remains to the patient, i.e. the physical and mental status of that life. The evaluation has to be made in relation to the medical procedures which would have to be instituted or maintained to sustain the patient's life. Thirion J observed that there were no doubt many whose susceptibilities would be offended at the thought that it could ever be reasonable for those responsible for the care of the disabled patient not to take whatever steps it may be reasonably possible to take to keep the patient alive - regardless of the quality of the life which the patient would have to endure if kept alive. A moment's reflection would however tell one that it happens regularly, especially in the case of the terminally ill, that

---

van die omstandighede van die geval volgens die regsopvattings van die gemeenskap op 'n redelike of onredelike wyse aangetas het.'"

66 *Ewels* 1975 (3) SA 590 (A)

decisions are taken to allow the patient to die rather than to prolong a life of suffering by taking life-support measures. He said he thought society would have regarded as grotesque the thought that the victim in *S v Williams*[67] should have been kept alive on the ventilator after it had been found that her brain had died. He admitted that this was perhaps the extremest of examples but said it nevertheless showed that the decision whether to undertake or to discontinue life-sustaining procedures involves a balancing exercise.

Advances in medical science and technology have made it possible for patients to be resuscitated who have suffered a cardiac arrest and cessation of breathing and who by the ordinary thinking of the community would therefore have been regarded as dead. It is right and proper that these advances in medical knowledge should be employed in the service of mankind but the opening of new frontiers has presented unique situations which require a change in society's attitudes to the process of dying. As it was put in *US Law Week*[68]:

'Medical advances have altered the physiological conditions of death in ways that may be alarming: highly invasive treatment may perpetuate human existence through a merger of body and machine that some might reasonably regard as an insult to life rather than its continuation.'

Patients may be resuscitated and maintained alive when there is not the remotest possibility that they would ever be able to consciously experience life. Within minutes after the supply of oxygenated blood to the brain has stopped the brain cells start dying off - that part of the brain which is responsible for intellectual life being the first to die. Inherent in resuscitation therefore is the very real danger that, by the time that the patient has been resuscitated, his brain may be all but destroyed while the autonomic nervous system and brain stem may nevertheless be able to keep the body biologically alive but securing only a life at the level of a plant or less. In such a situation the doctor or the patient's family has to decide whether it would be justified or reasonable to institute or maintain life-sustaining procedures or treatment which could prolong the life of the patient. In making an evaluation of this kind one must be careful, said Thirion J, to avoid making a judgment according to one's own

---

67 *S v Williams* 1986 (4) SA 1188 (A)

68 58 *US Law Week* 4936

predilections or even to facilely give effect to views expressed by the patient when he was still in good health[69].

Thirion J agreed that the hastening of a person's death is ordinarily not justified and is therefore wrongful even when the person is terminally ill and suffering unbearable pain but stated that this is not an absolute rule. It has come to be accepted that the doctor may give a terminally ill patient drugs with the object of relieving his pain, even if, to the doctor's knowledge, the drugs will certainly shorten the patient's life[70]. Thirion J then posed the question whether, if it would be reasonable for the applicant in the present case to discontinue the artificial nutritioning of the patient knowing that such a step would result in the death of the patient, why would it not be reasonable for someone to simply suffocate the patient to death? The deprivation of food would as assuredly kill the patient as the deprivation of oxygen. He said the distinction is to be found in society's sense of propriety - its belief that things should happen according to their natural disposition or order. The person who pre-empts the function of the executioner and kills the condemned man while he is taking the last few steps to the gallows, acts wrongfully irrespective of his motive for killing the condemned man. He acts wrongfully because he has no right to meddle in the matter.

In Thirion J's view, the distinction between the act of the doctor who, while following the precepts and ethics of his profession, prescribes a drug in a quantity merely sufficient to relieve, and with the object of relieving, the pain of his patient, well knowing that it may also shorten the patient's life, and the act of the doctor who prescribes an overdose of the drug with the object of killing his patient, is that the former acts within the legitimate context and sphere of his professional relationship with his patient while the latter does not act in that context. Consequently, society adjudges the former's conduct justified in accordance with its criterion of

---

69 Thirion J was of the view that the proper approach is that adopted by McKenzie J in *Re Superintendent of Family and Child Service and Dawson* (1983) 145 DLR (3d) 610 which was quoted with approval by Lord Donaldson MR in *Re J (a minor)* [1990] 3 All ER 930 at 936: "It is not appropriate for an external decision-maker to apply his standards of what constitutes a liveable life and exercise the right to impose death if that standard is not met in his estimation. The decision can only be made in the context of the disabled person viewing the worthwhileness or otherwise of his life in its own context as a disabled person - and in that context he would not compare his life with that of a person enjoying normal advantages." Thirion J said he did not think that the learned Judge meant to convey in the first sentence of the above passage that an external decision-maker ever has a right to impose death.

70 *R v Adams* 1957 *Crim LR* 365; Smith and Hogan *Criminal Law* 6th ed at 313. Glanville Williams *Textbook on Criminal Law* 2nd ed p 280 gives the following example: "Suppose that a patient with brain damage is on a ventilator (a respirator); he is unconscious, but the machine keeps his heart and lungs going mechanically. The doctor decides that there is no chance of recovery, so he 'pulls the plug'. There is general agreement that he is entitled to do so. This is not a case where, by commencing to treat the patient, the doctor has put him in some peril to which he would not otherwise have been subject." (as quoted by the court in *Clarke* fn 55 *supra*)

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

reasonableness and therefore not wrongful, while it condemns the conduct of the latter as wrongful. He stated that the distinction between what is wrong and what is right cannot always be drawn according to logic. Logic does not dictate the formation of society's legal or moral convictions. The distinction, he said, can also be justified on rational grounds. The doctor who brings about the death of his patient by prescribing an overdose of the drug with the object of killing the patient, causes the death of the patient in a manner which is unrelated to his legitimate function as a doctor. He changes not only the course but also the cause of his patient's death. The court held that to allow conduct of this nature would open the door to abuse and subject people to the vagaries of unauthorised and autocratic decision-making[71]. Thirion J found that in determining legal liability for terminating a patient's life there was no justification for drawing a distinction between an omission to institute artificial life-sustaining procedures and the discontinuance of such procedures once they have been instituted; nor was there any virtue in classifying the discontinuance of such procedures as an omission. He observed Van den Heever[72] states that to explain an omission giving rise to an action in the light of previous conduct is pure sophistry. Just as in the case of an omission to institute life-sustaining procedures legal liability would depend on whether there was a duty to institute such procedures, so in the case of the discontinuance of such procedures, liability would depend on whether there was a duty not to discontinue such procedures once they have been instituted. A duty not to discontinue life-sustaining procedures could not arise if the procedures instituted have proved to be unsuccessful. If life-sustaining procedures which have been instituted have proved to be unsuccessful there would be no point in continuing them and consequently they may be discontinued. Thirion J observed that in *S v Williams*[73] the life-sustaining procedures were held to have been unsuccessful even though they achieved the maintenance of the patient's heartbeat, blood circulation and respiration. He said that the decision must therefore be seen as authority for the view that the mere

---

71 Thirion J quoted J K Mason and R A McCall-Smith *Law and Medical Ethics* 2nd ed, at p 233: "There are those who say that any distinction between a commission and an omission to act when both have the same effect is no more than an illusion - the responsibility and the intention of the actor are the same. We, by contrast, believe that a morally significant difference between inactivity and action exists and that this rests on a firmer base than a mere intuition. The essence of discrimination lies in the means to obtain the same end, in that the taking of active steps implies an autocratic control over the way in which the event occurs. The doctor who administers a drug intended to end the life of a suffering patient determines the moment and the manner of the patient's death. The action of the drug changes the physical cause of death and this must be a matter of importance. The process is quite different from allowing another agency, eg illness, to cause death. Activity, moreover, directly confronts those views which concede that death is the one hazard of life which is beyond the ambit of legitimate human intervention."

72 Van den Heever FP *Aquilian Damages in South African Law* at p 38

73 *Williams* fn 67 *supra*

restoration of certain biological functions cannot be regarded as the saving of the patient's life. The maintenance of life in the form of certain biological functions such as the heartbeat, respiration, digestion and blood circulation but unaccompanied by any cortical and cerebral functioning of the brain, cannot be equated with living in the human or animal context. If, then, the resuscitative measures were successful in restoring only these biological functions then they were in reality unsuccessful and consequently artificial measures of maintaining that level of life, such as naso-gastric feeding, could also be discontinued.

He stated that it would be unreasonable to suggest that if it was known at the time when resuscitation was undertaken that it would only be possible to restore the quality of life which the patient now had, the doctors would then have been under a duty to undertake resuscitation at all. Why then would there now be a duty to maintain this quality of life by artificial means?

Thirion J observed that the patient did not experience his environment at all. There was no social interaction, no registering of sensation. All this was so because the capacity of the brain for a cognitive and cognitive life had been destroyed. The gross damage to the brain which led to the destruction of this capacity was irreparable. In short, the brain had permanently lost the capacity to induce a physical and mental existence at a level which qualifies as human life. In these circumstances he was of the view that, judged by society's legal convictions, the feeding of the patient did not serve the purpose of supporting human life as it is commonly known and the applicant, if appointed as *curatrix*, would act reasonably and would be justified in discontinuing the artificial feeding and would therefore not be acting wrongfully if she were to do so[74]. Thirion J concluded that it could be said that the *curatrix* would

[74] Thirion J stated that: "This conclusion makes it unnecessary to deal with the argument advanced by counsel for the applicant that the discontinuance of the artificial feeding regime would not in law be the cause of the patient's death if he were to die as a result of such discontinuance. A brief reference to *S v Williams* would however not be out of place. That was an appeal from a conviction for murder. The victim had been shot and wounded. She suffered severe brain damage which necessitated her being coupled to a ventilator to maintain her breathing. When it was ascertained that her brain was dead the ventilator was uncoupled and her heartbeat and breathing ceased in consequence thereof. On appeal the argument was raised that the uncoupling of the ventilator was the legal cause of the victim's death and not the gunshot wound. The Appellate Division assumed in favour of the appellant that the victim was still alive when the ventilator was uncoupled but, this notwithstanding, rejected the argument that the uncoupling of the ventilator was a cause of the victim's death." He noted that: "On the assumption that the victim was alive when the ventilator was uncoupled, it seemed obvious that the uncoupling of the ventilator accelerated the moment of death and therefore in a sense caused it. It is however clear that a factual causal connection is not enough to entail legal liability. There is no agreement among the writers as to what the additional factor should be. Glanville Williams *Textbook of Criminal Law* 2nd ed at p 381 says that the further test to be applied to the 'but-for' cause (i.e. the *conditio sine qua non*) in order to qualify as legal causation is not a test for causation but a moral reaction. The question is whether the result can fairly be said to be

not be acting in the best interests of the patient if she were to discontinue the artificial nutritional regime of the patient. Consequently he made an order in the following terms:

1. That Shirley Colette Clarke (the applicant) be appointed as *curatrix* to the person of Frederick Cyril Clarke (the patient).

2. That the powers which the applicant shall have in her capacity as *curatrix* to the person of the patient shall include the power:
   (i) to agree to or to withhold agreement to medical or surgical treatment for the patient and for that purpose to have the patient admitted to or discharged from any hospital, nursing home or institution for the care of geriatric patients;
   (ii) to authorise or direct the continuance or discontinuance of any treatment to which the patient is at present being subjected, including the continuance or discontinuance of any naso-gastric or other non-natural feeding regime.

3. It is declared that the applicant, in her capacity as *curatrix* to the person of the patient, would not act wrongfully or unlawfully
   (i) if she authorises or directs the discontinuance of the naso-gastric or any other non-natural feeding regime for the patient;
   (ii) if she withholds agreement to medical or surgical treatment of the patient save such treatment as may seem to her appropriate for the comfort of the patient, notwithstanding that the implementation of her decisions may hasten the death of the patient.

4. That the applicant's costs of the application, the costs of the *curator ad litem* appointed in terms of the first order prayed, as well as the costs of the first and second respondents incurred up to 4 December 1991, shall be paid out of the estate of the patient.

---

imputable to the defendant. It involves a value judgment. Snyman *Strafreg* 2nd ed at 72 favours the 'adekwasie veroorsakingstoets'. These are but two of many suggested tests. It appears, however, from *S v Mokgethi en Andere* [1990 (1) SA 32 (A)] that matters of policy also are relevant to the enquiry and that the court should guard against allowing liability to exceed the bounds of reasonableness, fairness and justice. So viewed, it would appear to me that the steps envisaged by applicant would not in law be the cause of the patient's death."

Discussion

This case is essentially about wrongfulness. It is a prime example of how the courts use public policy as a determinant of wrongfulness[75]. This approach has not gone uncriticised and du Bois[76] observes that Boberg's somewhat cynical description of wrongfulness as but 'a cloak of respectability for judicial gut-reaction' appears to have been vindicated. He notes that while this has not affected the continued pliability of the boundaries of civil liability, nor the capacity of the courts to resolve novel disputes, it does represent an erosion of the most important promise held out by the *boni mores* criterion, namely to render the process and the basis of the judicial development more transparent and certain.

It is worth considering these sentiments more closely in the context of *Clarke* and the cases that preceded it. In *Ex Parte Die Minister Van Justisie: In Re S v Grotjohn*[77] it was held that whether a person who instigates, assists or puts another in a position to commit suicide commits an offence depends on the facts of the particular case. The mere fact that the last act of the person committing suicide is such person's own, voluntary, non-criminal act does not necessarily mean that the other person cannot be guilty of any offence. Depending upon the factual circumstances the offence can be murder, attempted murder or culpable homicide. The facts were that Grotjohn was absolved of a charge of the murder of his spouse who was partially paralysed and suffered from manic depression. Her marriage to Grotjohn had reached a particularly unhappy and tense stage and was near breaking point. She withheld from him his 'conjugal rights' and he had commenced a relationship with a widow whom he subsequently married after his wife's death. On the day in question, his gun, the butt of which had broken off just behind the trigger, was with a friend but on the urging of the deceased he retrieved it. In her presence he dismantled the gun in order to

---

75 Du Bois F 'Getting Wrongfulness Right: A Ciceronian Attempt' 2000 *Acta Juridica* p1 notes that: "By adopting the notion that the wrongfulness of conduct depends on whether it is *contra bonos mores*, South African lawyers have endowed the law of delict with a standard for demarcating the scope of civil liability that was inherently flexible and simultaneously made explicit the purpose of judicial development of this part of the law – to ensure that it remains in step with the society it is meant to serve. This splicing of a candid recognition that judges not only apply law, but also develop it, with an insistence that this serves a legitimate function, largely obviated the need to pursue legal evolution behind a screen of questionable interpretations and re-interpretations of 'foreseeability', 'cause', and other conceptual contortions. The development of a concept that at once guides the judicial development of a major branch of the common law deserves to be regarded as one of the foremost achievements of South African lawyers."

76 Du Bois fn 75 *supra* at page 3

77 *Grotjohn* fn 59 *supra*

ascertain whether the two pieces could be re-attached. To do this he had to remove the triggerguard and as result the trigger was exposed. The deceased blamed him that the gun was broken and wanted to know if it could still shoot in that condition. In order to show her that it could he fired a shot from the balcony into the ground. Thereafter an argument flared up over the widow in the course of which the deceased became angry and said she was going to shoot herself. Grootjohn then fetched a bullet from somewhere in the flat, loaded the gun in her presence and handed it to her telling her to shoot herself if she wanted because she was a burden. She took the gun with one hand, put it on the floor between her feet said "I will", aligned the barrel with her right eye and pulled the exposed trigger with her foot. She died immediately. The court *a quo* found Grotjohn not guilty of murder.

In *S v Hartmann*[78] the accused, a medical practitioner, was charged with the murder of his father, aged 87, who for many years had been suffering form a carcinoma of the prostate. Thereafter secondary cancer had manifested itself in his bones, more particularly his ribs. Until 21 August 1974 the deceased had been living with the accused's brother in Pretoria where he had received X-ray treatment for the cancer growths in hospital there. The accused had visited him there and on one occasion found him to be bedridden and suffering great pain. The accused was very close to his father and had thereafter induced his father to come to Cape Town by air, whence he was transferred to the Ceres Hospital as a private patient of the accused. There was no longer any question of a cure. The deceased was very emaciated, incontinent and on pain-killing drugs. By 11 September he was in a critical state of ill-health and expert medical evidence described him as being moribund and close to death. The accused had instructed a nursing sister to give the deceased an injection of 1/2 gr. of morphine, which she had reluctantly done. An hour later the accused had himself got a further ampule of 1/2 gr. of morphine from the sister and placed it in the deceased's drip. The accused had remained with the deceased and about 11/2 hr. later, at 11 p.m., obtained 250 mgr. of pentothal from the sister and injected it into the drip. Within seconds of his doing so the deceased died, pentothal not being an analgaesic but of use in anaesthesia and, unless properly controlled, having fatal effects. The Court found that the accused had not desired to end his father's life: his motive had been

78 *Hartmann* 1975 (3) SA 532 (C)

compassionate, to relieve his father of the further endurance of pain and the continuation of a pitiable condition. He was, however, aware that his act would inevitably terminate his father's life.

The court held that that the accused clearly entertained that intention which was an essential ingredient of murder and that as to evidence that the deceased had consented to the administration of such a drug, that that would not constitute a defence to the charge. It held accordingly, that the accused's act of 'mercy-killing' made him guilty of murder as charged and that in regard to a suggestion by the state that sentence be postponed until after disciplinary action had been taken by the Medical Council, that it was up to the court to make a decision and that in any event it would be inappropriate to postpone the sentence. It was further held that, regard being had to the mitigating factors, that the accused should be sentenced to one year's imprisonment, the accused to be detained until the rising of the Court and the balance of the sentence to be suspended for one year.

Van Winsen J referring to the case of *R. v Makali*[79], observed that the law was clear that it nonetheless constitutes the crime of murder even if all that an accused has done is to hasten the death of a human being who was due to die in any event. He noted that it has more than once been held in the Appellate Division that the fact that the deceased wished to be killed does not exclude the criminal responsibility of him who gratifies the deceased's wish. See, for instance, *S v Peverett*,[80] and *S v Robinson and Others*,[81]. The court referred to the judgment of Holmes JA in the case of *S v V* [82], to the effect that:

"Punishment should fit the criminal as well as the crime, be fair to the accused and to society and be blended with a measure of mercy."

Van Winsen J said that this was a case, if ever there was one, in which, without having to be unfair to society, full measure can be given to the element of mercy.

---

79 *Makali* 1950 (1) SA 340 (N)
80 *S v Peveritt* 1940 AD 213
81 *S v Robinson* 1968 (1) SA 666 (AD).
82 *S v V* 1972 (3) SA 611 (AD) at p 614

Strauss[83] refers to a number of unreported cases namely *R v Davidow* (1955), *S v de Bellocq* (1968), *S v McBride* (1979) and *S v Marengo*(1990). In the firstmentioned case the accused's mother was suffering from an incurable disease on account of which she suffered unbearable pain and was in a constant state of despair. Davidow loved his mother dearly and did whatever was in his power to obtain medical attendance and have her cured if possible. When all his attempts had failed, he requested a friend – in a moment of despair – to kill his mother by means of a fatal injection. His friend flatly refused. At the time of the request Davidow had been in a state of extreme tension. Sometimes in discussions with others about his mother he burst into tears. It was also observed that he sometimes wept in his sleep. His mother often expressed the wish in his presence that she could be dead and said that she could no longer bear the excruciating pain. Finally Davidow decided to relieve her from further pain and suffering. He visited her in hospital and during a severe emotional outburst, shot her in the head with a revolver, killing her. The previous night he had written a note to his brother telling the latter of his intention to relieve their mother of her pain and suffering and that as he did not have the courage to kill himself, he expected to be sentenced to death. Davidow was effectively charged with murder. A psychiatrist testified that the accused had developed an obsession to help his mother and that this obsession induced and irresistible impulse in him to kill her. When he committed the act, the psychiatrist concluded that he acted automatically and involuntarily. The psychiatrist for the prosecution contested the finding of irresistible impulse but agreed with the conclusion at which the defence psychiatrist had arrived. The accused was acquitted by the jury that tried him.

In *S v de v Bellocq*, the accused, a young woman and her husband were immigrants from France. Her husband was employed by the Council for Scientific and Industrial Research in connection with the search for oil. He and the accused were newly married and when they had arrived in the country some months earlier, she was pregnant. She gave birth a month later to a premature child. She was very pleased to have this child and for the first three weeks or so nothing was seen to be wrong with it. The child had to be kept at the nursing home although she was discharged because it had to be put in an incubator for a while and treated. After three weeks on a visit to

---

83 Strauss fn 29 *supra* at p339 to 341

the nursing home she found that the child had been taken to hospital and a few days later the baby was diagnosed as suffering from toxoplasmosis. The accused had been a medical student in Paris for some four years and knew what this disease was and what its prognosis was – that the child was already in effect an idiot and would have to be fed with a tube through the nose and into the stomach. There was no chance of the child living for any length of time and at her trial a prominent paediatrician said that if it had been his child he would not have treated it medically. The child was kept at the hospital for some weeks and then sent home. While bathing the child the accused decided that it would be best to end its life and drowned it. She was charged with murder. The judge accepted that she had been in a highly emotional state and that she was in a puerperal state when a woman is inclined to be more emotional than the normal person. Nonetheless from her own confession she had intended to kill the child and it could not be said that her emotional state had reduced the intention to anything less than an intention to kill. However on the facts of the case, the judge held that there would be no object in sending the accused to prison, nor would a suspended sentence be appropriate. The sentence was that the accused was discharged and required to enter into recognisances to come up for sentence within six months after the date of sentence if called upon. She was not required to deposit any money in connection with the recognisances. The accused was never called upon to come up for sentence so that in actual fact no sentence was imposed.

In *S v McBride*, the accused killed his wife whom he dearly loved. Over the years her health had deteriorated drastically and this affected him severely. At different times in the past she had nursed her sister and mother, both of whom died in painful circumstances of cancer. Both the accused and his wife believed that she too was dying of cancer. Simultaneously with the deterioration of his wife's health, the spouses experienced a deterioration of their financial position. After a series of depressing events the accused decided to take his wife's life and then his own. He shot and killed her, but before he could kill himself he was saved through the intervention of others. Ironically the post mortem examination showed that she did not have cancer. Their fears would probably have been dispelled if she had agreed to submit to a proper and full medical examination but she had refused to do so. The accused was found not guilty by reason of mental illness and declared a state

President's patient. The judge recommended that the earliest possible consideration be given to the accused's release.

In *S v Marengo*, the accused, a 45 year old unmarried woman intentionally killed her father by shooting him in the head with a pistol that he had kept next to his bed for self-protection. He was 81 years of age and suffering from cancer. The accused pleaded guilty to a charge of murder. She told the court that her actions had been motivated by her desire to end her father's terrible suffering and to end the mental and physical deterioration brought about both to herself and to her father by his constant pain and the hopeless and helpless condition he was in. She was convicted and sentenced to three years in prison suspended in its entirety for five years subject to the usual conditions. The judge found that she was a victim of extreme circumstances which would never be repeated. Imprisonment, he said, was not called for in her case as it could totally destroy her. A factor in the case was that as a young girl she had been totally isolated by her mother from other people. The accused had numerous traits of an obsessive, compulsive personality. She was incapable of making friends and her entire life consisted of going to work as an insurance clerk and going home to her flat where she locked herself in. She had been told by doctors that her condition could continue for many years while she felt that she could not go on for 'even days, never mind years'.

In *S v Williams*[84] the accused in the course of a robbery had shot the deceased in her home and seriously wounded her. She received emergency medical treatment and was subsequently placed on a respirator but the left side of her brain was already dead. The next day there was no evidence of brain activity and the doctor came to the conclusion that her brainstem had died. Her heart and lungs were kept going thereafter for a period of some 48 hours by the respirator whereafter it was disconnected. The accused tried to argue that this was a novus actus interveniens and that his shooting the deceased had not been the cause of her death.

It was held that where a person is wounded so seriously that it would, in the absence of prompt medical intervention, very soon lead to his death, and such person is kept

---

84 *Williams* fn 67 *supra*

alive artificially by means of a breathing apparatus (a respirator), the eventual disconnecting of the respirator cannot be seen as the act causing death. It is merely the termination of a fruitless attempt to save the life, i.e. a fruitless attempt to avert the consequences of the wounding. The causal connection between the wounding of the deceased and his eventual death exists from beginning to end and is not interrupted and eliminated by the disconnecting of the respirator. The court said that the fact that it did not decide the issue whether the view held by medical science, viz that the moment of death of a person occurs when there is brainstem death, should also be accepted in law, should not be seen as an indication that the abovementioned view should be accepted by South African courts. The court decided the instant appeal on the traditional view of the community that death occurs when breathing and heartbeat are no longer present.

It is submitted that it is abundantly clear from the circumstances of all of the cases above what the *boni mores* on the subject of euthanasia is. There is no doubt that the court in Clarke's case was completely correct in its conclusion that the actions proposed by Mrs Clarke would not be wrongful and that it was not just a question of the judge's 'gut feel' in this particular case although he admittedly did not refer to these unreported cases. Strauss notes that although Hartmann was struck off the roll by the Medical and Dental Council he was subsequently reinstated and the press coverage indicated that his action generally evoked sincere and strong compassion. If the courts in these cases had been obliged to use a less flexible test of wrongfulness, it is submitted that they would have been forced to come to conclusions that were manifestly unjust and that did not accord with the legal convictions of the community.

Clarke is not authority for legal recognition of the so-called Living Will. Taitz[85] states that it is interesting to note the evidence led in *Clarke* to the effect that the patient (a qualified medical practitioner) was a life member of SAVES (the South African Voluntary Euthanasia Society) He had signed a 'living will': a document directing that should he in the future contract a terminal illness with no hope of recovery or become permanently unconscious, he must not be kept alive by artificial means but be allowed to die. Taitz points out that Thirion J stated that these statements undoubtedly

85 Taitz JR 'Euthanasia and the "Legal Convictions of Society" in a South African Context' (1993) 110 *SALJ* 440

stemmed from a settled, informed and firmly held conviction on the patient's part that should he ever be in the condition in which he has been since the cardiac arrest no effort should be made to sustain his life by artificial means. Nonetheless the judge placed no emphasis on these directions neither did he rule on the validity of the "living will". The reason for this, says Taitz probably lies in the fact that as yet the "living will" has not yet been recognised in South African law. An examination of the document shows that it is not a will, nor can it be described as a power of attorney. He states that perhaps at best it may be regarded as a written directive having no force of law.

9.2.10 Jansen van Vuuren v Kruger[86]

Facts

The plaintiff, M, lived in a homosexual relationship with one Van Vuuren in Brakpan. It appeared that they were fairly well-known residents of that town and that the nature of their relationship was either generally known or surmised. During the beginning of 1990 they began a business venture in and moved to Nylstroom. They had, however, retained some links with Brakpan. During that period the plaintiff applied for life insurance cover from Liberty Life Insurance Company. The company required a medical report, including a report on the plaintiff's HIV status (i.e. whether the plaintiff was infected with the human immunodeficiency virus). The first defendant had been the plaintiff's general medical practitioner since 1983 and the plaintiff nominated him to prepare the medical report. For purposes of an HIV blood test a sample was drawn on 27 March 1990 at the second defendant's laboratory. The result was positive and the second defendant informed the first defendant accordingly. The first defendant in consequence arranged an appointment with the plaintiff in order to consult with him on the outcome. That took place on 10 April 1990. The plaintiff was extremely upset and distressed. He was also concerned about a possible leak and raised the issue with the first defendant, who promised to respect his wish to keep it confidential. The following day during the course of a game of golf with Dr van Heerden, also a general medical practitioner, and Dr Vos, a dentist, the first defendant

---

86 *Jansen van Vuuren* fn 19 *supra*

disclosed the plaintiff's condition to them. The plaintiff and these three doctors moved in the same social circle in Brakpan. The plaintiff was engaged in a business venture with Van Heerden's wife. Vos had in the past been the plaintiff's dentist and the first defendant's ex-wife and her parents were on friendly terms with Van Vuuren. Van Heerden, in due course, informed his wife. Whether Vos informed his was not established in evidence, but all assumed that he had. The news spread and the plaintiff became aware of this fact. He instituted an action for damages in an amount of R50 000 for breach of privacy against his general medical practitioner, the respondent. The plaintiff's case against the first defendant was pleaded in these terms: the first defendant had been his general medical practitioner; in consequence he owed him a duty of confidentiality regarding any knowledge of the plaintiff's medical and physical condition which might have come to his notice; he became aware of the plaintiff's HIV status; it was a term of the agreement which established the doctor-patient relationship that the first defendant and his staff would treat this information in a professional and confidential manner; in breach of the agreement and in breach of his professional duties the first defendant 'wrongfully and unlawfully' disclosed the test results to third parties; in consequence the plaintiff had suffered an invasion of, and had been injured in, his rights of personality and his right to privacy. Sentimental (i.e. non-pecuniary) damages of R50 000 were initially claimed, but the amount was increased to R250 000 during the course of the trial. When the plaintiff died, during the course of the trial, of an AIDS-related disease, the appellants were appointed executors of his estate. The Court *a quo* dismissed the claim but granted leave to appeal. The respondent admitted the existence of the professional relationship, his duty to respect the plaintiff's confidence and the term of the agreement as alleged, but raised the absence of wrongfulness on three alternative bases: (a) the communication had been made on a privileged occasion, (b) it was the truth and was made in the public interest, and (c) it was objectively reasonable in the public interest in the light of the boni mores. On appeal no reliance was placed on (b). It was argued on behalf of M that two alternative causes of action had in fact been pleaded, namely breach of contract and the *actio iniuriarum* and that in respect of the former *animus iniuriandi* was not an element (this was done in order to counter in advance a submission that *animus iniuriandi* had not been established). The argument was premised on the fact that the term of the contract was common cause and it proceeded on the assumption

that there was no reason why the breach of an agreement not to commit an *iniuria* ought not to be actionable by a claim for damages.

Judgment

Harms AJA stated that as a general rule, and irrespective of the ultimate onus, a plaintiff who relies on the *actio iniuriarum* must allege *animus iniuriandi* (*Moaki v Reckitt & Colman (Africa) Ltd*[87]; cf *Minister of Justice v Hofmeyr*[88] - something the plaintiff had failed to do. However, as was pointed out in *Jackson v SA National Institute for Crime Prevention and Rehabilitation of Offenders*[89] the averment need not be express if "the alleged *injuria* is obviously an infringement of personality, or where the facts pleaded allow of an inference of *animus injuriandi*".

Harms AJA noted that the *actio iniuriarum* protects a person's *dignitas* and *dignitas* embraces privacy. He said that although the right to privacy has on occasion been referred to as a real right or ius in rem (see, for example, *S v A and Another*[90], it is better described as a right of personality. The present case, he said, concerned the alleged invasion of this right by means of a public disclosure of private facts. As far as the public disclosure of private medical facts is concerned, the Hippocratic Oath, formulated by the father of medical science more than 2 370 years ago, is still in use. It requires of the medical practitioner 'to keep silence' about information acquired in his professional capacity relating to a patient, 'counting such things to be as sacred secrets'. But, said Harms AJA, the concept even predates Hippocrates. He referred to Oosthuizen, Shapiro and Strauss[91]:

"In a work written in Sanskrit presumed to be from about 800 BC Brahmin priests were advised to carry out their medical practices by concentrating only on the treatment of a patient when they entered a house and not divulging information about the sick person to anyone else. In ancient Egypt also the priestly medical men were under strict oaths to retain the secrets given to them in confidence. They worshipped in the temples of Isis and Serapis, a healer of the sick, and also of their son, Horus, who was usually called Harpocrates by the Greeks and pictured with his finger held to his mouth. The name for medicine, ars muta (dumb art), is used in Roman poetry by Virgil in Aeneid XII. The Pythagorean school in Greece, to which medical men especially belonged, considered silence as one of the most important virtues."

---

87 *Moaki* 1968 (3) SA 98 (A) at 104E-105E

88 *Hofmeyr* 1993 (3) SA 131 (A) at p 154

89 *Jackson* 1976 (3) SA 1 (A) at 13F-H

90 *S v A* 1971 (2) SA 293 (T) at 297D-G)

91 Oosthuizen GC , Shapiro HA and Strauss SA *Professional Secrecy in South Africa* (1983) at p 98

He noted that according to the rules of the SA Medical and Dental Council it amounts to unprofessional conduct to reveal 'any information which ought not to be divulged regarding the ailments of a patient except with the express consent of the patient'. The reason for the rule is twofold. On the one hand it protects the privacy of the patient. On the other it performs a public interest function[92]. Harms AJA stated that the duty of a physician to respect the confidentiality of his patient is not merely ethical but is also a legal duty recognised by the common law[93]. He stated that one is, as always, weighing up conflicting interests and, as Melius de Villiers indicated, a doctor may be justified in disclosing his knowledge 'where his obligations to society would be of greater weight than his obligations to the individual' because '(t)he action of injury is one which *pro publica utilitate exercetur*'. To determine whether a *prima facie* invasion of the right of privacy is justified, he said, it appears that, in general, the principles formulated in the context of a defence of justification in the law of defamation ought to apply. It was therefore not surprising, said Harms AJA, that the defences pleaded by the first defendant in justification have the ring of defamation defences, namely privilege, truth and public benefit and, in general terms, the *boni mores*. He noted that on appeal no reliance was placed on the defence of truth and public interest and that nothing more thus needed be said about it.

The court found it convenient to apply the test stated by Burchell *Principles of Delict* in the context of defamation to the defence of privilege of the sort presently under consideration[94].

---

92 Harms AJA referred to *X v Y and Others* [1988] 2 All ER 648 (QB) at 653a-b where Rose J said: "In the long run, preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients 'will not come forward if doctors are going to squeal on them'. Consequently, confidentiality is vital to secure public as well as private health, for unless those infected come forward they cannot be counselled and self-treatment does not provide the best care. . . ." He noted that a similar view was expressed by the Supreme Court of New Jersey in *Hague v Williams* [1962] 181 *Atlantic Reporter* 2d 345 at p 349: "A patient should be entitled freely to disclose his symptoms and condition to his doctor in order to receive proper treatment without fear that those facts may become public property. Only thus can the purpose of the relationship be fulfilled."

93 He referred in this regard to de Villiers M *The Law of Injuries* at p 108. As far as present-day law is concerned, the legal nature of the duty is accepted as axiomatic. See, for example, *Sasfin (Pty) Ltd v Beukes* 1989 (1) SA 1 (A) at 31F-33G; Neethling *Persoonlikheidsreg* 3rd ed at 236; McQuoid-Mason *The Law of Privacy in South Africa* at p 193-4. He noted, however, that the right of the patient and the duty of the doctor are not absolute but relative. See *S v Bailey* 1981 (4) SA 187 (N) at 189F-G; *Sasfin* case *supra*; *Sage Holdings Ltd v Financial Mail (Pty) Ltd* 1991 (2) SA 117 (W) at 129H-131F; *Financial Mail case* (AD) *supra* at 462F-463B.

94 Burchell J *Principles of Delict* at p180 states that: "It is lawful to publish . . . a statement in the discharge of a duty or the exercise of a right to a person who has a corresponding right or duty to receive the information. Even if a right or duty to publish material and a corresponding duty or right to receive it does not exist, it is sufficient if the publisher had a legitimate interest in publishing the material and the publishee had a legitimate interest in receiving the material."

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Harms AJA observed that the duty or right to communicate and the reciprocal duty or right to receive the communication may be legal, social or moral[95]. He said a legal duty to communicate would, for example, exist in respect of the duty of a medical practitioner to testify in court[96] or to disclose a notifiable disease in terms of section 45 of the Health Act[97]. A social or moral duty, he said, is exemplified in *Hague v Williams*[98] where it was held that knowledge of a child's pathological heart condition was not of such a confidential nature that it prevented the physician from disclosing it extracurially to an insurer to whom the parents had applied for life insurance on the child.

Harms AJA held that the objective facts that are of relevance in assessing whether the disclosure was justified, were these:

1. The HIV-infection and AIDS-related illnesses are considered by many to be the major health threat of our day. In a paper by the head of the AIDS Centre at the SA Institute for Medical Research, Mrs Christie (who testified for the plaintiff) gave the following graphic description:

> "It is a modern day scourge which has already claimed the lives of thousands of people worldwide. The World Health Organisation estimates that between five to ten million people are infected with the AIDS virus and that there will be an exponential increase in the number of AIDS cases in the next few years. In the absence of a cure or vaccine, the only way to stop the spread of this deadly disease is by prevention of infection in the first place. This is clearly the task of education which is the only current tool available to combat the AIDS epidemic".

Although the concept of "education for prevention" is not new, it takes on special significance in the context of AIDS. For one thing, there is widespread ignorance and subsequent fear of the disease. The public is afraid of AIDS and the media has also helped to reinforce existing fear through sensationalist and sometimes inaccurate coverage on the topic. This is largely detrimental to society because it is a well-documented psychological fact that fear arousal is

---

95 The court referred in this regard to *De Waal v Ziervogel* 1938 AD 112 at p 121-2. It noted that this case incorrectly assumed that privilege negatives *animus iniuriandi*, whereas the modern point of view is that it negatives wrongfulness. The court also referred to *Borgin v De Villiers and Another* 1980 (3) SA 556 (A) atp 571F-G and *Marais v Richard en 'n Ander* 1981 (1) SA 1157 (A) at p 1167

96 *Davis v Additional Magistrate, Johannesburg, and Others* 1989 (4) SA 299 (W) at 303E-I

97 Health Act No 63 of 1977

98 *Hague* [1962] 181 *Atlantic Reporter* 2d 345

not conducive to learning or promoting behavioural change. In fact, fear elicits denial so that people tend to block out what they hear or see. Another difficulty in promoting socially responsible behaviour is that AIDS deals with so many taboo subjects, including: sex, blood, death, promiscuity, prostitution, abortion, homosexuality, drug use, etc. These taboos makes AIDS an uncomfortable subject to deal with and creates impediments in the learning process.

2. Levy AJ described the nature of HIV-infection and the resultant AIDS in these terms:

"A disturbing feature of HIV is that it has the characteristic that it may remain for years in its host without showing any positive symptoms in the carrier. Antibodies in the carrier develop after about three months, but in the interim, that carrier has become and remains a potent source of infection without demonstrating any of the symptoms of HIV and despite the absence of antibodies. AIDS is incurable and fatal and it probably is the greatest public health threat of this century. There is a lack of information concerning the nature of the disease which has led to great fear amongst the public generally that it is easily transmittable and, of course, the fact that the disease has evidenced itself chiefly amongst homosexual and bisexual people has led to a further intolerance by the community of the victims of the disease. The disease is transmitted via body fluids, chiefly blood, semen and mother's milk, as well as the vaginal fluids. Saliva apparently, although the virus may be found in it, would not carry sufficient of the virus to infect a recipient. It is also found in urine and tears. With blood as a source of infection, there was a great spread of the disease amongst persons requiring blood transfusion, notwithstanding their non-participation in high risk behaviour and, in particular, children have become its victims through infection through blood transfusion, particularly amongst haemophiliacs. The spread of the disease amongst persons practising normal sexual behaviour, presumably originating from homosexuals or bisexuals, or from persons who had become infected through sharing drug injection apparatus with infected persons, has led to a justifiable fear, as indicated earlier, that the spread of the disease will reach enormous proportions in a comparatively short time. At present there seems to be no cure for the disease. Plaintiff had for some time been taking drugs thought to be of assistance in combating or repressing the activity of the virus, but as has been observed, it nevertheless led to the onset of AIDS and his death during the course of the trial. It seems to be generally accepted for the present time that there is no recognised cure for the disease, and any victim of the virus who reaches the AIDS stage, must expect his illness to be fatal. The likelihood of advancing to the AID syndrome is, apparently, very high. Some of the writers to which I have been referred speak of a 50 per cent chance, but of greater importance perhaps *in casu* is the fact that such persons, while demonstrating no overt symptoms of the disease in the absence of blood tests to reveal the presence of antibodies in the blood, nevertheless remain highly infective of any sexual partner or recipient of their blood, whether accidentally or by way of transfusion, or through sharing needles in intravenous drug taking."

3. Even though the virus is highly infective, it is far less infectious than many other common viruses and can only be transmitted through exchange of certain body fluids, viz semen, vaginal fluids and blood. The mode of spread of the infection generally follows well-defined routes, namely unprotected sexual intercourse,

the injection of infected blood, the infection of an unborn foetus whilst in the womb and, in exceptional cases, the infection of a newborn baby through the medium of breast milk.

4. Not a single case of occupationally acquired HIV has been confirmed in South Africa. Although health care workers are therefore at risk, the risk is small and arises only if through an invasive procedure infected blood enters the worker's blood stream.

5. There are many pathogens that are more infectious than HIV, such as hepatitis B, and a medical practitioner must, in the course of his ordinary practice, take steps to prevent their spread. Some of them are usually sufficient to prevent the spread of HIV in a professional context.

6. There is a reported instance in the USA of a dentist who infected one or more of his patients but that was through the use of instruments which he had used on himself in somewhat extra-ordinary circumstances. But his own HIV-infection was not occupationally acquired.

7. Reference has already been made to the Council's rule 16 which is of general application. In addition, the Council formulated a guideline in 1989 in connection with HIV in these terms:

"The health care professions are fully aware of the general rules governing confidentiality. Council is confident that if doctors fully discuss with patients the need for other health care professionals to know of their condition, in order to offer them optimal treatment and also to take precautions when dealing with them, the reasonable person of sound mind will not withhold his consent regarding divulgence to other health care workers."

If having considered the matter carefully in the light of such counselling, the patient still refuses to have other health care workers informed, the patient should be told that the doctor is duty bound to divulge this information to other health care workers concerned with the patient. All persons receiving such information must of course consider themselves under the same general obligation of confidentiality as the doctor principally responsible for the patient's care. If it were found that an act or omission on the part of a medical

practitioner or dentist had led to the unnecessary exposure to HIV infection of another health care worker, the Council would see this in a very serious light and would consider disciplinary action against the practitioner concerned.

An important aspect of it is that the patient has to be informed of the doctor's obligation to make a disclosure. That gives the patient the opportunity to say why it is in fact not necessary - something that the plaintiff was denied. The first defendant not only did not seek to obtain the plaintiff's consent to a disclosure; to the contrary, he promised not to divulge the information.

8. The prestigious College of Medicine has a similar guideline.

9. There are some medical practitioners who refuse to treat known infected patients out of fear for their safety.

10. There are in the case of HIV and AIDS special circumstances justifying the protection of confidentiality. By the very nature of the disease, it is essential that persons who are at risk should seek medical advice or treatment. Disclosure of the condition has serious personal and social consequences for the patient. He is often isolated or rejected by others, which may lead to increased anxiety, depression and psychological conditions that tend to hasten the onset of so-called full-blown AIDS.

11. Section 45 of the Health Act[99] empowered the Minister of Health to declare any medical condition to be a notifiable medical condition, presumably in order to promote public health. Diseases that have been declared in terms of this provision include cholera, leprosy, malaria, measles, poliomyelitis, tuberculosis and viral hepatitis. HIV-infection or AIDS-related diseases are, on the other hand, not notifiable diseases.

12. Dr Van Heerden had treated the plaintiff once only. That was in January 1990, during the first defendant's absence. He diagnosed, as mentioned, an oral fungal

---

99 Health Act fn 97 *supra*

infection. It was a minor problem which, he said, would normally respond promptly to appropriate treatment. There was no evidence of an intrusive procedure having been performed or of any risk having been created.

13. The plaintiff had consulted Dr Vos in his professional capacity prior to and during September 1987 but not since. There is no evidence of the nature of any procedure carried out by Vos on the plaintiff, whether of a risky nature or not.

14. The plaintiff had settled in Nylstroom a few months before the disclosure on the golf course.

According to Harms AJA, although justification is an objective question, Levy AJ considered the first defendant's motive in making the communication to be of paramount importance but he did not find that the 'retrospective exposure' of Vos or Van Heerden justified it. As to Vos, his view was that as far as the first defendant knew the plaintiff was still his dentist and was likely to treat him in the future. It was also likely that he would not on such occasion have informed Vos of his condition in spite of having been advised otherwise by Mrs Christie. As to Van Heerden, it was held (contrary to an earlier finding) that the first defendant had been unaware of the treatment during January. Nevertheless, since Van Heerden was one of a group of 16 doctors in Brakpan who were on call from time to time for all off-duty practitioners in town, it was required that he should be informed for his own sake as well as for the better treatment of the plaintiff, should the occasion arise.

Harms AJA stated that concerning these findings a number of points arise. First, since one is dealing with the issue of wrongfulness, the first defendant's honesty, *bona fides* and motive (except, possibly, if malice is in issue) are beside the point[100]. Second, at the time of the disclosure the plaintiff had moved to Nylstroom and the likelihood of him calling upon the services of either Vos or Van Heerden was remote. If the argument is taken to its logical conclusion, he said, health care workers, at least those in Transvaal, would have to be informed. Third, there was no factual basis for the

---

100 *De Waal v Ziervogel* fn 95 *supra* p 122-3; *Delange v Costa* 1989 (2) SA 857 (A) at p 862D-E and compare *Tsose v Minister of Justice and Others* 1951 (3) SA 10 (A) at p 17.

finding that the plaintiff would have failed to inform his future medical attendants of his illness. The evidence was merely that he did not wish to return to Vos for treatment because he did not want to advise him of his condition for fear of local gossip. Lastly, he said the Court was in his view correct in not relying on the 'retrospective exposure' because, as indicated, there was no evidence of it in either instance.

Harms AJA stated that in determining whether the first defendant had a social or moral duty to make the disclosure and whether Van Heerden and Vos had a reciprocal social or moral right to receive it, the standard of the reasonable man applied. With that in mind, he took the view that he had no such duty to transfer, nor did Van Heerden and Vos have the right to receive, the information. He saw the matter in this light: AIDS is a dangerous condition. That on its own does not detract from the right of privacy of the afflicted person, especially if that right is founded in the doctor-patient relationship. A patient has the right to expect due compliance by the practitioner with his professional ethical standards: in the present case the expectation was even more pronounced because of the express undertaking by the first defendant. Vos and Van Heerden had not, objectively speaking, been at risk and there was no reason to assume that they had to fear a prospective exposure. As Levy AJ stated, the real danger to the practitioner lies with the patient whose HIV condition had not been established or (due to the incubation period) cannot yet be determined. In consequence Harms AJA concluded that the communication to Vos and Van Heerden was unreasonable and therefore unjustified and wrongful.

He said that it was extremely difficult to make such an award because there were no obvious signposts. Nevertheless, the right of privacy is a valuable right and the award must reflect that fact. Harms AJA found that aggravating factors included the fact that a professional relationship was abused notwithstanding an express undertaking to the contrary. So, too, the breach created the risk of further dissemination by others. The evidence also established that the publication of a person's HIV condition increases mental stress and that the plaintiff was seriously distressed by the disclosure. And stress hastens the onset of AIDS - something which may have occurred in this instance. On the other hand, the disclosure was limited to two medical men who, it was reasonable to assume, would have dealt with the information with some

circumspection. The nature of the plaintiff's condition was in any event such that it would inevitably have become known at some stage. He had, to an extent, already severed his links with Brakpan. There is no evidence that his friends ostracised or avoided him; it was rather a case of his having chosen to withdraw from society, something he would probably in any event have done. In the light of all this the court took the view that R5 000 would be a just award.

Discussion

The question of confidentiality of medical information and the privacy of patients is one of the central issues of debate in the law on health service delivery. *Jansen Van Vuuren v Kruger*[101] predates the Constitution but it is submitted that the decision is not inconsistent with constitutional rights and principles[102] and is likely to remain a valid legal precedent on the subject of the unauthorised disclosure by a health professional of confidential information relating to a patient. This case illustrates just how easy it is to breach patient confidentiality. Health workers may talk to one another about a

---

101 *Jansen van Vuuren* fn 86 *supra*

102 Thus for instance in *Investigating Directorate: Serious Economic Offences and Others v Hyundai Motor Distributors (Pty) Ltd and Others; In Re Hyundai Motor Distributors (Pty) Ltd and Others v Smit No and Others* 2001 (1) SA 545 (CC) Langa DP stated that: "The right to privacy has previously been discussed in judgments of this Court. In *Bernstein and Others v Bester and Others NNO*, [1996 (2) SA 751 (CC)] Ackermann J characterises the right to privacy as lying along a continuum, where the more a person inter-relates with the world, the more the right to privacy becomes attenuated. He stated: 'A very high level of protection is given to the individual's intimate personal sphere of life and the maintenance of its basic preconditions and there is a final untouchable sphere of human freedom that is beyond interference from any public authority. So much so that, in regard to this most intimate core of privacy, no justifiable limitation thereof can take place. But this most intimate core is narrowly construed. This inviolable core is left behind once an individual enters into relationships with persons outside this closest intimate sphere; the individual's activities then acquire a social dimension and the right of privacy in this context becomes subject to limitation.' (Footnotes omitted.) The right, however, does not relate solely to the individual within his or her intimate space. Ackermann J did not state in the above passage that when we move beyond this established 'intimate core', we no longer retain a right to privacy in the social capacities in which we act. Thus, when people are in their offices, in their cars or on mobile telephones, they still retain a right to be left alone by the state unless certain conditions are satisfied. Wherever a person has the ability to decide what he or she wishes to disclose to the public and the expectation that such a decision will be respected is reasonable, the right to privacy will come into play. The protection of the right to privacy may be claimed by any person... As we have seen, privacy is a right which becomes more intense the closer it moves to the intimate personal sphere of the life of human beings, and less intense as it moves away from that core. This understanding of the right flows, as was said in *Bernstein*, [*supra*] from the value placed on human dignity by the Constitution."
Similarly Epstein JA observed in *De Reuck v Director of Public Prosecutions, Witwatersrand Local Division, and Others* 2003 (3) SA 389 (W) that: "The right to privacy includes the right to be freed from intrusions and interference by the State and others in one's personal life. However, privacy, like other rights, is not absolute. In *Bernstein and Others v Bester and Others NNO* [*supra*] Ackermann J described the right to privacy as 'an amorphous and elusive' concept. The learned Justice said: '(T)he truism that no right is to be considered absolute implies that from the outset of interpretation each right is always already limited by every other right accruing to another citizen. In the context of privacy this would mean that it is only the inner sanctum of a person, such as his/her family life, sexual preference and home environment, which is shielded from erosion by conflicting rights of the community rights and the rights of fellow members placing a corresponding obligation on a citizen, thereby shaping the abstract notion of individualism towards identifying a concrete member of civil society. Privacy is acknowledged in the truly personal realm, but as a person moves into communal relations and activities such as business and social interaction, the scope of personal space shrinks accordingly.' In *S v Jordan and Others (Sex Workers Education And Advocacy Task Force and Others as Amici Curiae)* 2002 (6) SA 642 (CC), O'Regan J and Sachs J stated that "Our Constitution values human dignity which inheres in various aspects of what it means to be a human being. One of these aspects is the fundamental dignity of the human body which is not simply organic. Neither is it something to be commodified. Our Constitution requires that it be respected. ...the constitutional commitment to human dignity invests a significant value in the inviolability and worth of the human body. The right to privacy, therefore, serves to protect and foster that dignity."

patient not realising that someone else who knows that patient could overhear them, they may go home and speak to a family member about a patient not knowing that the patient is known to that family member. This case indicates that the breach of confidentiality does not have to be an announcement to the entire neighbourhood. It could be a careless remark to one other person who then conveys it to another and a chain of communication is established until, as in the case of *Jansen Van Vuuren*, just about everyone in town knows. Once such confidentiality is breached it cannot be repaired. It is not as if, once broken, a replacement can be found or the defect can be mended. It is submitted with respect that, whilst the judgment is in principle laudable, the award of damages in this case was rather low given the fact that this case was based on legal rules which although compensation driven, tend to be punitive in nature since no amount of money can make up for the impairment of a person's *dignitas*. The court in *Jansen Van Vuuren v Kruger* canvassed in detail the nature of HIV and AIDS and the social stigma that attaches to it. It also did not escape the court's attention that the patient was extremely upset at the diagnosis and specifically requested the doctor not to tell anyone else. The fact that the patient relocated, it is submitted, was not sufficient to mitigate the damage to his rights of personality. The disclosure would in all likelihood have lead to a situation where he could not have returned to Brakpan if something went wrong for him in Nelspruit. Furthermore, Nelspruit was another small town not so far from Brakpan that a resident of the latter could not end up there once again spreading the news of M's illness. Unfortunately, in matters of this nature, the world can often be a lot smaller than it should be. It is further submitted that the casual manner and circumstances in which M's doctor apparently breached his patient's right of confidentiality, especially given the fact that health professionals, more than most, are aware of the need for silence and despite his patient's obvious distress at the news of his illness, was more than a little reprehensible. The court even conceded that the stress to the patient caused by the unauthorised disclosure and the subsequent litigation could have accelerated the onset of AIDS and the patient's consequent death before the litigation was concluded. The amount awarded in damages was a tenth of the R50 000 that was initially claimed. In the course of proceedings this claim was increased to R250 000. Even in 1993 when the judgment was reported R5000 is not a great deal of money, given the likely impact of the disclosure on M's life.

Violations of the right to privacy affect the *dignitas* of a person. The court in *S v Jana*[103] analysed the nature of *dignitas* in some detail[104]. The right to privacy reinforces and upholds the right to human dignity[105]. Human dignity is not only a right but a fundamental value of the Constitution. The court in *Hermanus v Department of Land Affairs: In Re Erven 3535 and 3536, Goodwood*[106] pointed out that a *solatium* is symbolic reparation. "It must not be an attempt to provide full redress for the claimant's emotional suffering. *Such an award, albeit symbolic, will serve the all important function of acknowledging the dignity and worth of the claimant.*"(writer's italics) Awards of damages in cases such as that of *Jansen van Vuuren v Kruger*, therefore fulfil two functions. They offer some form of comfort to the person who has been wronged but they also serve the important function of recognising his or her right to human dignity and worth. It is submitted that in view of this latter function and the importance of human dignity in South African society, the previously conservative approach of the courts in awarding such damages should be revisited in cases involving violations of fundamental constitutional rights if the weight attached by society to such rights is to be reflected in the amounts of the damages awarded.

---

103 *Jana* 1981 (1) SA 671 (T)

104 *Jana* fn 103 *supra*. It stated that "Melius de Villiers' much quoted definition is: 'That valued and serene condition in his social or individual life which is violated when a person 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.' He adds that the rights to an unimpaired person, dignity and reputation are 'absolute or primordial rights' 'which every man has, as a matter of natural right' and he points out that: 'The word dignitas must be understood in a wide sense, and not as merely equivalent to the elevated public position of the Roman citizen. Injuries against dignity evidently comprise all those injuries which are not aggressions upon either the person or the reputation; in fact, all such indignities as are violations of the respect due to a free man as such.' De Wet and Swanepoel define *dignitas* as 'waardigheid, selfrespek en geestelik onverstoorheid'. Following Joubert, it regards *dignitas* as one aspect of the wider concept 'eer' which Joubert defines as 'die erkenning van die geestelik-sedelike waarde van die mens as kroon van die skepping, as wese wat uitstyg bo die bloot fisies-psigiese van die stoflike natuur en die dierelewe'. Van der Merwe and Olivier define *dignitas* as: 'Die benadeelde... se eie gevoel van eer en agting van sy persoonlikheid'. As for the Courts, in *R v Van Tonder* 1932 TPD 90 at 93 Greenberg JP equated *dignitas* with 'self-respect, mental tranquillity'. In *R v Holliday* 1927 CPD 395 at 401 the Court spoke of 'a man's rights of personality, his primordial rights of 'son état civile'' and said that *dignitas* 'includes a man's self-respect' and 'a woman's right of privacy in regard to her body'. In *R v Terblanche* 1933 OPD 65 at 68 De Villiers JP described *dignitas* as 'the complainant's own sense of her dignity; in other words her self-respect', and in *R v X and Y* 1938 EDL 30 at 32 Pittman JP referred to 'that ethical interest... to which the Romans gave the name *dignitas* '. It is submitted that: '*Dignitas* 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..."

105 Thus in *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others* 1999 (1) SA 6 (CC), Ackermann J stated: "As we have emphasised on several occasions, 34 the right to dignity is a cornerstone of our Constitution. Its importance is further emphasised by the role accorded to it in s 36 of the Constitution which provides that: 'The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. . . .' Dignity is a difficult concept to capture in precise terms. At its least, it is clear that the constitutional protection of dignity requires us to acknowledge the value and worth of all individuals as members of our society...The present case illustrates how, in particular circumstances, the rights of equality and dignity are closely related, as are the rights of dignity and privacy."
In *S v Jordan* fn 102 *supra* the constitutional court said that: "As we observed before, the constitutional commitment to human dignity invests a significant value in the inviolability and worth of the human body. The right to privacy, therefore, serves to protect and foster that dignity."

106 *Hermanus* 2001 (1) SA 1030 (LCC)

Damages for *injuria* are not generally in respect of patrimonial loss. In fact, although damages can be claimed for *injuria* where there is patrimonial loss[107], the court in *Minister of Finance and Others v EBN Trading (Pty) Ltd*[108] stated that in an action based on an *injuria* in which the plaintiff claims special damages the requisites for a claim under the *actio legis Aquiliae* must be alleged and proved. The question of damages in relation to various kinds of delict was discussed in some detail in this case. Magid J stated that in Roman-Dutch law, unlike English law, there are no hard and fast categories of delicts, nor is it necessary to label a cause of action. In our law all delicts give rise to claims based on either the *actio injuriarum* or on the *lex Aquilia*. Provided facts are alleged in a pleading which justify the relief sought in accordance with the principles of our law, the pleading will disclose a cause of action without the delict being named. Similarly, if the evidence led in an action justifies a judgment consistent with our legal principles no label need be attached to the claim on which it is based. He said that in Roman law, of course, the principles of the law developed from various types of actiones; but today we deal essentially in principles rather than actions[109].

---

107 For example in *Weeks and Another v Amalgamated Agencies Ltd* 1920 AD 218 damages in a sum which could only have represented special damages were awarded against the messenger of the court and the execution creditors for the wrongful attachment and sale in execution of the plaintiff's goods. The significance of this judgment is that the majority of the Court concluded that the messenger of the court honestly believed he was acting lawfully, which is to say that he was not guilty of *dolus*. Nor was there any specific finding in the majority judgment (though there was in that of the minority) to the effect that he had been guilty of *culpa*. In other words, the majority judgment in Weeks is an instance of an award of special damages in an action based on an *injuria* in which one of the defendants at least was acquitted of fault in the widest sense (*dolus* or *culpa*). In fact, it seems clear that the majority judgment held that the messenger was liable as he had not acted strictly in accordance with his duties under the relevant Magistrates' Courts Act 32 of 1917. The same court noted that: "In *Viviers v Kilian* 1927 AD 449, a case dealing with damages for adultery, special damages were awarded. But by the very nature of things, if the adultery constituted an injuria justifying an award of general damages for *contumelia*, the conduct of the defendant must have been intentional and accordingly, for the purpose of an Aquilian action, have amounted to dolus."

108 *EBN Trading* 1998 (2) SA 319 (N)

109 Magid J observed that: "Voet 47.10.18, in dealing with *injuriae*, said (Gane's translation): 'Action for indemnity for patrimonial loss under Aquilian law. By our customs besides there is this rule that, in addition to this action for honourable and profitable amends, a person who has suffered a wrong has no other right of redress either private or public for the wrong wreaked upon him, but has only a private action for indemnity under the Aquilian law, when perhaps the wrong inflicted has also redounded in a loss to his household estate.'
Roman-Dutch law has been developed in our jurisprudence and the possibility of claiming actual patrimonial loss caused by an injuria as, contrary to Voet's view, been expressly approved in the Appellate Division. In *Whittaker v Roos and Bateman; Morant v Roos and Bateman* 1912 AD 92 at 123 Innes J said:
'(F)or in respect of injuria compensation may be given for the insult, indignity and suffering caused by the wrongful act. It often happens that actual pecuniary loss is caused by an injuria; and under such circumstances the modern and convenient practice is not to bring two separate actions, but to claim damage under both heads. In the present case I entertain no doubt that the element of injuria is present, and that being so, the plaintiff's claim cannot be restricted to mere patrimonial loss.' Subsequently, however, in *Matthews and Others v Young* 1922 AD 492 De Villiers JA, after an exhaustive review of the authorities said, at 505: 'We have seen that for the intentional infringement of another's right there were two actions available under the Roman-Dutch law: the actio injuriarum or rather the amende honorabel & profitabel - the latter to recover sentimental damages - and the *actio ex lege Aquilia*, where direct patrimonial loss had been sustained. In our practice, however, the necessity for bringing two separate actions has long since disappeared, and there is no objection to the plaintiff in one and the same action now claiming, if so advised, both kinds of redress. The declaration does not betray what kind of damages the plaintiff claims, but from the evidence and the argument, it is clear that the plaintiff is only concerned about compensation. The action is, therefore, an Aquilian action for patrimonial loss based upon dolus, an intentional violation of plaintiff's legal rights.'
In effect the learned Judge said, like Innes J in Roos & Bateman (*supra*) that, if one suffers an injuria which causes patrimonial loss, one can claim one's special and general damages in the same action, but he specified that if one claims

The patient's right to privacy is an important element of the trust factor in the relationship between the patient and the provider of health care services. The duty on the part of health professionals to observe the right of a patient to privacy is clearly not absolute since the right to privacy is not absolute[110] and as usual, a balancing act is often necessary in determining whether or not confidential medical information should be disclosed. There is no special privilege accorded to health professionals asked to testify before a court of law with regard to their patients. In *Ex parte James*[111] the applicant asked for an order authorising and directing two medical practitioners to swear affidavits to be used in support of a petition relating to the mental condition of the respondent. The two practitioners were prepared to do so but were precluded from doing so by the rules of the Medical Council. The court held that the rules of a professional association cannot confer a power which is neither inherent nor statutory. It saw no difference between the present case and the case of any member of the public who alleges that he is ready to place relevant evidence by way of an affidavit before the court provided the court orders him to do so. The court distinguished the case of *Parkes v Parkes*[112] on the basis that it was a trial proceeding saying that "there is all the difference in the world" between the making of such an order and the grant in motion proceedings of an order authorising a named person to make an affidavit. In response to the explanation of counsel that a doctor might be guilty of unprofessional conduct if in breach of the Hippocratic Oath, he divulged information concerning his patient, the court said that they should address themselves to the Medical Council which is the arbiter of professional conduct and it is to this Council that they should address themselves. The application was refused. The applicant was, however, granted leave to apply for a rule nisi on the same papers. In *Parkes* the wife brought an action against her husband for divorce on the ground of his adultery. She alleged that he was suffering from venereal disease which he had not contracted from her. A doctor who had refused to give any information concerning the husband to the wife's attorney prior to the trial was subpoenaed as a witness by the wife. The doctor was

---

special damages, the claim is Aquilian and must accord with the requirements of such an action. The enquiry in this case is whether modern developments in South African law law have changed the principles laid down in *Matthews v Young* (supra).

110 *De Reuck v Director Of Public Prosecutions, Witwatersrand Local Division, And Others* fn 102 *supra*; *Qozeleni* fn 16 *supra*

111 *James* 1954 (3) SA 270 (SR)

112 *Parkes* 1916 CPD 702

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

asked in court whether he had treated the husband for venereal disease. He claimed professional privilege and refused to reply. The judge ruled that he had to answer the question and he then told the court that he had treated the husband for such disease. In *Botha v Botha* [113] two doctors from Pietermaritzburg, Dr. Lind, a psychiatrist and Dr. Roper, a general practitioner, had been subpoenaed to give evidence for the defendant. After entering the witness-box and being sworn, and after having thereafter given evidence with respect to their qualifications, they have both refused to give evidence of what the plaintiff and the defendant revealed to them during consultations which they had with the parties. They claimed that their ethical rules prevent them from disclosing confidential information which they had been given by the plaintiff and the defendant in their capacities as medical advisers to the parties. They said that, if they were to reveal such information, they would be in breach of their hippocratic oath which they as doctors were bound to observe. It was clear that the evidence which was sought to be led was relevant to one of the main issues in the case, namely whether the custody of the minor child, Jacobus, should be awarded to the father or to the mother. The evidence of the doctors would have a bearing on the issue as to the fitness or otherwise of the parties to be awarded custody of this child. Leon J stated that in his judgment, a doctor cannot claim privilege for confidential communications from his patients[114]. He stated that it was of interest to note that in England the Law Reform Committee had recently concluded that the balance of convenience was against professional privilege being extended to a relationship such as that between a doctor and a patient. But in para. 1 of the report it is stated that the Judge has -

"a wide discretion to permit a witness, whether a party to the proceedings or not, to refuse to disclose information where disclosure would be a breach of some ethical or social value and non-disclosure would be unlikely to result in serious injustice in the particular case in which it is claimed".

Leon J was doubtful whether a discretion exists at all in the circumstances with which he was concerned. He was of the view that once the evidence is material and relevant it ought to be admitted without further ado. But, he said, if it is correct to hold that there exists a residual discretion in a court to refuse to allow such evidence to be given, even in circumstances such as those with which he was concerned, he was

113 *Botha* 1972 (2) SA 559 (N)

114 He referred to Hoffman, *SA Law of Evidence*, 2nd ed., p. 194; *Parkes v Parkes*, fn 112 *supra*; and also *C. v C.*, (1946) 1 All E.R. 562.

firmly of the opinion that such discretion should in this case be exercised in holding that the evidence must be given. He observed that it is in the public interest that justice must be done. The confidential relationship between doctor and patient must yield to the requirement of public policy that justice must be done and must be seen to be done. This is particularly so, said Leon J, in this sort of case where a minor child is concerned and where the court as Upper Guardian of such child has a duty to ensure, as far as it is within its power to do so, that the future of such child will best be served by that child being placed in the custody of the parent who is most fitted to take care of him.

There are also statutory requirements for the disclosure of medical information. Thus the Compensation for Occupational Injuries and Diseases Act[115] stipulates that –

(1) A medical practitioner or chiropractor shall within 14 days after having for the first time examined an employee injured in an accident or within 14 days after having diagnosed an occupational disease in an employee, furnish a medical report to the employer concerned in the prescribed manner: Provided that where the employee was at the time of the diagnosis of an occupational disease not employed, the medical report shall be furnished in the prescribed manner to the commissioner.

(2) If the commissioner or the employer individually liable or mutual association concerned, as the case may be, requires further medical reports regarding an employee, the medical practitioner or chiropractor who has treated or is treating the employee shall upon request furnish the desired reports in the manner and at the time and intervals specified or prescribed.

(3) If a medical practitioner or chiropractor fails to furnish a medical report as required in subsection (1) or (2) or in the opinion of the commissioner or the employer individually liable or mutual association concerned, as the case may be, fails to complete it in a satisfactory manner, such party may defer the payment of the cost of the medical aid concerned until the report has been

115 COID Act No 130 of 1993 section 74

furnished or completed in a satisfactory manner, and no action for the recovery of the said cost shall be instituted before the report has been so furnished or completed.

(4) No remuneration shall be payable to a medical practitioner or chiropractor for the completion and furnishing of a report referred to in subsection (1) or (2).

(5) A medical practitioner or chiropractor shall at the request of an employee or the dependant of an employee furnish such employee or dependant with a copy of the report referred to in subsection (1).

The Occupational Health and Safety Act[116]stipulates –

"Any medical practitioner who examines or treats a person for a disease described in the Second Schedule to the Workmen's Compensation Act, 1941 (Act 30 of 1941), or any other disease which he believes arose out of that person's employment, shall within the prescribed period and in the prescribed manner report the case to the person's employer and to the chief inspector, and inform that person accordingly."

Sometimes prejudice or some form of adverse consequence for the person to whom the record relates is attached to the failure to disclose a medical record. In terms of section 29A (7) the Medical Schemes Act[117] which deals with the imposition of waiting periods before a person is entitled to benefits from the scheme –
"A medical scheme may require an applicant to provide the medical scheme with a medical report in respect of any proposed beneficiary only in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12 month period ending on the date on which an application for membership was made."

The Road Accident Fund Act[118] stipulates that –
The Fund or an agent shall not be obliged to compensate any person in terms of section 17 for any loss or damage-
e) suffered as a result of bodily injury to any person who-

116 OHS Act No 85 of 1993 section 25
117 Medical Schemes Act No 131 of 1998
118 RAF Act No 56 of 1996 Section 19

(i) unreasonably refuses or fails to subject himself or herself, at the request and cost of the Fund or such agent, to any medical examination or examinations by medical practitioners designated by the Fund or agent;

(ii) refuses or fails to furnish the Fund or such agent, at its or the agent's request and cost, with copies of all medical reports in his or her possession that relate to the relevant claim for compensation; or

(iii) refuses or fails to allow the Fund or such agent at its or the agent's request to inspect all records relating to himself or herself that are in the possession of any hospital or his or her medical practitioner.

It is recognised in section 14 of the Constitution which states that everyone has the right to privacy which includes the right not to have –

(a) their person or home searched;

(b) their property searched;

(c) their possessions seized or

(d) the privacy of their communications infringed.

This last is obviously the most relevant to the relationship between patient and provider. It does not expressly cover a situation, however, where for instance the provider acquired information which is deeply personal to the patient and which the patient had not him or herself divulged to the provider. The classic example is, of course, blood test results. The question is whether the right to privacy is infringed when such information is disclosed by the provider to someone other than the patient. The court in *Jansen Van Vuuren* obviously answered this question in the affirmative. However, there is an allied issue relating to the question of ownership of medical records, such as the documentation bearing the test results in *Jansen Van Vuuren* and which states that it is the provider and not the patient who owns those records and the former may therefore dispose of them as he pleases and may, inter alia, refuse to give the patient access to such records. Since the records obviously contain the personal information of the patient, the latter has a very direct and vested interest in how it they are disposed of. This seems to be at odds with the concept of the provider's ownership

of the records[119]. It is submitted that the patient's right of privacy in fact severely restricts the doctor's right of ownership in the patient records in the sense that he is not free to dispose of them as he sees fit. For instance he may not publish them in a newspaper or even a medical journal in such a manner that the patient can be identified from them. He cannot allow unauthorised persons access to them within his own consulting rooms, neither can he display them to members of the patient's family. All of these actions would constitute a violation of the patient's right to privacy. The statement of Strauss[120] that the rule that a patient will only ordinarily have access to medical records only by way of discovery presents a major obstacle to patients who are still contemplating legal action against a doctor has now largely been addressed by the Promotion of Access to Information Act[121]. At the same time the safeguards of the private law around non-disclosure of medical records have also now been statutorily reinforced by the provisions of this Act[122]. Section 1 of the Act defines

---

119 Strauss (fn 29 *supra* at p110) states that the ownership of records made by the doctor for his own purposes cannot be legally in any doubt. He is the exclusive owner of these records…The doctor has a moral obligation to keep the patient informed on his health but he does not have to let the patient read his medical record.

120 Strauss fn 29*supra* at p111

121 Promotion of Access to Information Act No 2 of 2000

122 Section 34 provides for mandatory protection of privacy of third party who is natural person in the case of records held by a public body. It states: (1) Subject to subsection (2), the information officer of a public body must refuse a request for access to a record of the body if its disclosure would involve the unreasonable disclosure of personal information about a third party, including a deceased individual.
(2) A record may not be refused in terms of subsection (1) insofar as it consists of information-
(a) about an individual who has consented in terms of section 48 or otherwise in writing to its disclosure to the requester concerned;
(b) that was given to the public body by the individual to whom it relates and the individual was informed by or on behalf of the public body, before it is given, that the information belongs to a class of information that would or might be made available to the public;
(c) already publicly available;
(d) about an individual's physical or mental health, or well-being, who is under the care of the requester and who is-
(i) under the age of 18 years; or
(ii) incapable of understanding the nature of the request,
and if giving access would be in the individual's best interests;
(e) about an individual who is deceased and the requester is-
(i) the individual's next of kin; or
(ii) making the request with the written consent of the individual's next of kin; or
(f) about an individual who is or was an official of a public body and which relates to the position or functions of the individual, including, but not limited to-
(i) the fact that the individual is or was an official of that public body;
(ii) the title, work address, work phone number and other similar particulars of the individual;
(iii) the classification, salary scale, remuneration and responsibilities of the position held or services performed by the individual; and
the name of the individual on a record prepared by the individual in the course of employment.
Section 63 provides for mandatory protection of privacy of third party who is natural person in the case of records held by a private body. It states-
(1) Subject to subsection (2), the head of a private body must refuse a request for access to a record of the body if its disclosure would involve the unreasonable disclosure of personal information about a third party, including a deceased individual.
(2) A record may not be refused in terms of subsection (1) insofar as it consists of information-
(a) about an individual who has consented in terms of section 72 or otherwise in writing to its disclosure to the requester concerned;
(b) already publicly available;
(c) that was given to the private body by the individual to whom it relates and the individual was informed by or on behalf of the private body, before it is given, that the information belongs to a class of information that would or might be made available to the public;
(d) about an individual's physical or mental health, or well-being, who is under the care of the requester and who is-
(i) under the age of 18 years; or

'personal information' as meaning "information about an identifiable individual, including, but not limited to-

(a) information relating to the race, gender, sex, pregnancy, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health, well-being, disability, religion, conscience, belief, culture, language and birth of the individual;

(b) information relating to the education or the medical, criminal or employment history of the individual or information relating to financial transactions in which the individual has been involved;

(c) any identifying number, symbol or other particular assigned to the individual;

(d) the address, fingerprints or blood type of the individual;

(e) the personal opinions, views or preferences of the individual, except where they are about another individual or about a proposal for a grant, an award or a prize to be made to another individual;

(f) correspondence sent by the individual that is implicitly or explicitly of a private or confidential nature or further correspondence that would reveal the contents of the original correspondence;

(g) the views or opinions of another individual about the individual;

(h) the views or opinions of another individual about a proposal for a grant, an award or a prize to be made to the individual, but excluding the name of the other individual where it appears with the views or opinions of the other individual; and

(i) the name of the individual where it appears with other personal information relating to the individual or where the disclosure of the name itself would reveal information about the individual,

but excludes information about an individual who has been dead for more than 20 years".

(ii) incapable of understanding the nature of the request,
and if giving access would be in the individual's best interests;
(e) about an individual who is deceased and the requester is-
(i) the individual's next of kin; or
(ii) making the request with the written consent of the individual's next of kin; or
(f) about an individual who is or was an official of a private body and which relates to the position or functions of the individual, including, but not limited to-
(i) the fact that the individual is or was an official of that private body;
(ii) the title, work address, work phone number and other similar particulars of the individual;
(iii) the classification, salary scale or remuneration and responsibilities of the position held or services performed by the individual; and
(iv) the name of the individual on a record prepared by the individual in the course of employment.

Sections 30 and 61 of the Act deal specifically with access to health records held by public and private bodies respectively. The difference between access to records in the public sector and access to records in the private sector is, in the view of the writer somewhat simplistically drawn by the Act. Section 11 gives the right of access to a record held by a public body in the following terms -

(1) A requester must be given access to a record of a public body if-

(a) that requester complies with all the procedural requirements in this Act relating to a request for access to that record; and

(b) access to that record is not refused in terms of any ground for refusal contemplated in Chapter 4 of this Part.

(2) A request contemplated in subsection (1) includes a request for access to a record containing personal information about the requester.

(3) A requester's right of access contemplated in subsection (1) is, subject to this Act, not affected by-

(a) any reasons the requester gives for requesting access; or

(b) the information officer's belief as to what the requester's reasons are for requesting access.

By contrast, the right of access to a record held by a private body is expressed in section 50 of the Act as follows-

(1) A requester must be given access to any record of a private body if-

(a) that record is required for the exercise or protection of any rights;

(b) that person complies with the procedural requirements in this Act relating to a request for access to that record; and

(c) access to that record is not refused in terms of any ground for refusal contemplated in Chapter 4 of this Part.

(2) In addition to the requirements referred to in subsection (1), when a public body, referred to in paragraph (a) or (b) (i) of the definition of 'public body' in section 1, requests access to a record of a private body for the exercise or protection of any rights, other than its rights, it must be acting in the public interest.

(2) A request contemplated in subsection (1) includes a request for access to a record containing personal information about the requester or the person on whose behalf the request is made.

A person may only request access to the record of a private body where he or she requires the record for the protection or exercise of any rights. The same qualification

is not present in section 11. Technically speaking a person can request access to a public record out of sheer curiosity and be entitled to that access. Section 45 does state that the information officer of a public body may refuse a request for access to a record of the body if (a) the request is manifestly frivolous or vexatious; or (b) the work involved in processing the request would substantially and unreasonably divert the resources of the public body. However, what is meant by (a) in the light of the provisions of section 11 (3)(b) is far from clear. The validity of the distinction is questionable because in terms of the Act, it is not so much the nature of the record that decides whether or not it falls within the ambit of section 11 or section 50 but rather the identity of the person having custody or possession of the record.

9.2.11 Castell v De Greef [123]

Facts

On 7 August 1989, the plaintiff underwent a surgical operation known as a subcutaneous mastectomy. The operation was performed by the defendant, a plastic surgeon. It was not a success and the plaintiff sued for damages. The plaintiff's mother, and probably also her grandmother, died of breast cancer. In 1982 the plaintiff underwent surgery for the removal of lumps in the breast. In 1989 further lumps were diagnosed. In view of the plaintiff's family history, her gynaecologist recommended a prophylactic mastectomy and referred her for this purpose to the defendant who saw her on 14 June 1989. The plaintiff and her husband discussed the operation with the defendant at some length. A surgical procedure was proposed involving the removal of as much breast tissue as possible with the simultaneous reconstruction of the plaintiff's breasts using silicone implants. Following the discussion, the plaintiff decided to go ahead with the operation. The plaintiff was admitted to the Panorama Medi-Clinic Hospital and the operation was performed the next day. Breast tissue was removed bilaterally, a 280 ml prosthesis was implanted on each side behind the pectoral muscle, and the areolae and nipples were repositioned. The repositioning of the areolae was achieved by the creation on each breast of a

123 *Castell* 1993 (3) SA 501 (C); 1994 (4) SA 408 (C)

superior pedicle or flap, which was then folded back on itself resulting in the areolae being repositioned some 3 cm above its former position. The reason for repositioning the areolae was to correct a pre-operative mild ptosis (drooping), the aggravation of which is one of the consequences of an implant. This method, known as 'transposition' was employed in preference to the 'free grafting' method by which the areolae are simply removed and grafted on in a different position. The former method had the advantage that the areolae are not totally detached from the surrounding skin and in this way the risk of necrosis is reduced. The operation had a high risk of complications, the main one being necrosis of the skin and underlying tissue, including the areolae and nipples. The reason was that the removal of the breast tissue and lactiferous ducts in which carcinoma may develop results in the cutting off of the main blood supply to the skin and areolar complex (areola and nipple). The only source of blood that remains is the subdermal plexus or layer of fat beneath the skin. The surgeon's dilemma is that the more of this tissue he leaves behind the less risk there is of necrosis but also the less effective the procedure is as a prophylaxis for cancer. Even without repositioning the areolae, they are at risk. If they are moved, the risk is increased, but more so if the 'free grafting' as opposed to the 'transposition' method is employed.

The operation was initially a success in the sense that upon completion all seemed well. Some 36 hours after the operation, however, the defendant observed a discolouration of the left nipple and first became concerned about the blood supply. He expressed this concern to the plaintiff. There was also a 'wedge shaped' area below the right areola which appeared pale and ischaemic. Later the same day, when the dressings were being changed, the plaintiff's husband observed the incision marks around both areolae. The defendant was called to the ward where the plaintiff confronted him with this, saying that he had promised her that he would not 'remove' the areolae. He replied that he had not 'removed' them but had 'moved' them. In the course of the next few days the discolouration of the plaintiff's left areolar complex worsened and by the time she was discharged from hospital on 13 August it had turned black. By this time, too, the area below the right areola had become discoloured but not to the same extent as the left areolar complex. Upon discharging the plaintiff from hospital, the defendant advised her that she would have to undergo further surgery but that it would first be necessary to wait and see what the extent of

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

the necrosis would be. On completion of the operation on 7 August the plaintiff was given a broad spectrum antibiotic intravenously as a prophylaxis against infection. Thereafter she was put on a related oral antibiotic and other medicines designed to prevent infection. When the plaintiff's dressings were changed at home on 14 August 1989, both she and a friend, a Mrs Pickering, who assisted her, noticed a discharge from the area immediately below and bordering on the right areola and also from the left areolar complex. They also detected an offensive smell. The following day there was no improvement. On Wednesday 16 August 1989, the plaintiff went to see the defendant at his rooms in Paarl as previously arranged. He assured her that the discharge was to be expected and was a consequence of the necrosis. He also explained that it was necessary to wait before undergoing surgery for the debridement of the dead tissue. The plaintiff testified that after the 16th the discharge seemed to get worse, as did the odour. She said she also experienced pain and began to feel feverish. Although her next appointment with the defendant was on Wednesday, 23 August, she arranged to come and see him on Monday the 21st as she was not feeling well. On this occasion he prescribed another antibiotic. On the 21st the plaintiff also began receiving laser treatment which was administered to the scars by Miss Susan Wessels, a physiotherapist. On 23 August the plaintiff again saw the defendant. On this occasion he told her that he would be away the following weekend, but that if there was a problem she should get in touch with his colleague, Dr Lückhoff. That weekend the plaintiff continued to suffer pain. She said she felt feverish and emotionally upset. On Sunday night, 27 August 1989, her husband took her to see Dr Lückhoff at the Panorama Medi-Clinic. He arranged for her to be admitted and she remained hospitalised until 11 September 1989. On Monday, 28 August, she was seen in hospital by the defendant who took swab specimens from both breasts and sent these off for analysis. Two days later, on Wednesday, 30 August, a debridement of the dead tissue was performed under a general anaesthetic. The plaintiff had lost the entire areolar complex on the left side and an area of skin (including a portion of the areola) below the nipple on the right side. Six days later, namely on 4 September, she underwent a further surgical procedure involving a skin graft to both breasts, the skin for this purpose being taken from high up under the left arm. In the meantime, the analysis of the swabs taken on 28 August revealed the presence of Staphylococcus aureus. According to the pathologist's reports received on 30 August and 1 September 1989 respectively, Staphylococcus aureus is resistant to both of the antibiotics that

had been prescribed for the plaintiff once she had left the hospital. A different antibiotic was then prescribed

In May of 1990, she underwent a further operation for the revision of the scars and spent one night in hospital. By this time, however, she had lost confidence in the defendant and the revision was performed by another plastic surgeon. On a subsequent occasion she had the original prosthesis removed and replaced by a smaller, 200 ml prosthesis, spending two nights in hospital for this purpose. Finally, in October of 1991 she underwent a further operation in the course of which the left nipple and areola were recreated. On this occasion she spent one night in hospital.

The plaintiff was satisfied with the final result and no further surgery was envisaged. As a result of the necrosis following the original operation, however, she had to undergo a number of additional surgical procedures which involved her in further expense. She also suffered pain and, for a long period, embarrassment and psychological trauma in consequence of the disfigurement of her breasts. Her claim against the defendant was for damages in the sum of R94 952,12. It was agreed by the parties that the defendant was under a duty of care towards plaintiff to perform the surgery (the subcutaneous mastectomy) with such professional skill, and utilising such procedures and materials as would reasonably be required of a specialist plastic surgeon and further under a duty of care to ensure that all reasonable steps were taken to ensure that plaintiff suffered no harm or damage other than such damage as normally resulted from the surgery in question.

The complaints against the defendant were as follows:

1. He performed the mastectomy and prosthesis implant simultaneously instead of in two stages.
2. He removed and repositioned the areolae unnecessarily, or alternatively without ensuring that the blood supply was sufficient to prevent necrosis.
3. He repositioned the areolae in breach of a specific agreement that he would not do so and that he would ensure that the plaintiff suffered no loss of sensation in the nipples.
4. He implanted a prosthesis which was larger than had been agreed upon.

5. On becoming aware that sloughing of the tissue was beginning to occur (on or about 10 August 1989) he failed to take steps to prevent or curtail this and in particular he failed to remove some of the sutures.
6. He failed to observe by not later than about 16 August 1989 that the plaintiff's breasts had become infected and failed to take proper steps to treat and prevent the spread of the infection, more particularly he failed to take a pus swab in order to identify the organism causing the infection and to administer an appropriate drug to combat it; and, as a last resort, to remove the prosthesis.
7. He failed to ensure that the breasts were symmetrical.
8. He adopted a suturing technique which made it more difficult to release the sutures should this become necessary to prevent or curtail necrosis.
9. He failed to warn the plaintiff of the risks involved in the operation and of the possible complications, and in particular failed to warn her that:
   (a) transpositioning the areolae would increase the risk;
   (b) it was not essential to transposition the areolae;
   (c) performing the mastectomy and reconstruction simultaneously involved a greater risk than if performed in two stages;
   (d) the risk of complications was as high as 50%;
   (e) in the event of a threatened post-operative necrosis virtually no steps could be taken to avert or curtail it.

The defendant denied that he had breached his obligations and that he had acted wrongfully, unlawfully or negligently. He admitted that there had been scarring of the plaintiff's breasts but averred that this was an unavoidable consequence of surgery. He averred also that the need for further surgery was a consequence of 'normal, expected and unavoidable complications' arising from the initial operation. He admitted that the plaintiff's breasts had become asymmetrical but averred that this was a normal and expected consequence of the operation.

Judgment

In the court *a quo*, Scott J made certain general observations regarding the duty of a medical practitioner towards his patient. He observed that both in performing surgery and in his post-operative treatment, a surgeon is obliged to exercise no more than reasonable diligence, skill and care and that he is not expected to exercise the highest

possible degree of professional skill (*Mitchell v Dixon*[124]). What is expected of him, said Scott J, is the general level of skill and diligence possessed and exercised at the time by members of the branch of the profession to which he belongs[125]. Scott J pointed out that it must also be borne in mind that the mere fact that an operation was unsuccessful or was not as successful as it might have been or that the treatment administered did not have the desired effect does not, on its own, necessarily justify the inference of lack of diligence, skill or care on the part of the practitioner. He said that no surgeon can guard against every eventuality, although readily foreseeable and that most, if not all, surgical operations involve to a greater or lesser extent an element of risk, and from time to time mishaps do occur, and will continue to occur in the future, despite the exercise of proper care and skill by the surgeon. Scott J noted that necrosis is a common complication in operations of the kind undergone by the plaintiff. It can and does frequently arise notwithstanding the utmost care on the part of the surgeon. Indeed, he said, it is one of the inherent risks associated not only with this operation but also with many other operations involving plastic surgery. The mere fact that it occurred in the present case did not, therefore, give rise to an inference of negligence on the part of the defendant.

Concerning the release of the sutures, the court examined the evidence and held that there was no reason to conclude that the decision of the defendant not to release the sutures was such that no reasonable plastic surgeon in his position would have adopted the same approach. It noted that the plaintiff testified that she was satisfied with the final result following reconstructive surgery and that had the sutures been released, there was every likelihood that necrosis would not have been averted and the plaintiff would have been left with additional, and perhaps unacceptable, scarring resulting from an unsuccessful attempt to avert the necrosis. The court then examined the evidence relating to the claim of failure to properly treat the infection and held that the plaintiff had failed to establish that there was an infection. It said that it followed that the defendant cannot be held to be negligent for having failed to detect an infection or to take steps to combat it and this ground of negligence accordingly failed. With regard to the repositioning the areolae without consent and failure to

---

124 *Mitchell* fn 1 *supra* at p525

125 The court referred to *Van Wyk v Lewis* (fn 3 *supra*) at 444; *Blyth v Van den Heever* 1980 (1) SA 191 (A) at 221A; *S v Kramer and Another* 1987 (1) SA 887 (W) at p 893E-895C and *Pringle v Administrator, Transvaal* fn 7 *supra* at p 384I-385E in this regard.

warn of the risks, Scott J held that the probabilities favoured the conclusion that the defendant explained to the plaintiff that he would reposition the areolae using a transpositional flap for this purpose, as opposed to the free grafting method, and that the plaintiff had either misunderstood the position at the time or later became confused as to what she had been told. The court noted that the plaintiff seemed to be an intelligent woman and this, according to the defendant, was the impression he also gained. He spent more than an hour discussing the operation with her and explaining what he proposed to do. This included answering questions. In the course of his explanation he drew little sketches on a pad to make things clearer. In these circumstances, said Scott J, there was no basis, in his view, for holding that any misunderstanding that may have arisen was the fault of the defendant. This ground of complaint therefore also failed.

Concerning the question of the warning the defendant was obliged to give with regard to the risks inherent in the operation the court first made certain general observations. Scott J, stated that a medical practitioner undoubtedly has a duty in certain circumstances to warn his patient of the risks involved in surgery or other medical treatment and, if he fails to do so, may incur liability for negligence. He said that the difficulty is to determine when that duty arises and what the nature and extent of the warning must be and noted that in *Richter and Another v Estate Hamman*[126] Watermeyer J adopted the approach of measuring the conduct of the doctor in question against the standard of the reasonable doctor faced with the same problem[127]. Scott J agreed with this approach. He stated that the 'reasonable doctor' test is one which is well established in South African law and is applied in relation to both medical diagnosis and treatment and that it affords the necessary flexibility and if properly applied does not 'leave the determination of a legal duty to the judgment of doctors', as suggested by Lord Scarman in *Sidaway v Governers of Bethlem Royal Hospital and Others*[128] in relation to the so-called 'Bolam principle'[129].

---

126 *Richter* fn 38 *supra*

127 Scott J referred to the following dictum of the court in *Richter* (fn 38 *supra*): "It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem. In reaching a conclusion a Court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do. The Court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence."

128 *Sidaway* [1985] 2 WLR 480 (HL) ([1985] 1 All ER 643 at 488 (in WLR, and at 649e in All ER)

129 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 (QB) ([1957] 2 All ER 118

Scott J observed that counsel had invited the court to adopt, if not in its entirety, certain aspects of the doctrine of 'informed consent'. He noted that this doctrine originated in certain jurisdictions of the United States of America and had been accepted in modified form by the Supreme Court of Canada[130]. The doctrine holds that a patient's consent to medical treatment is vitiated if he is given inadequate information concerning the proposed treatment and that, subject to certain exceptions, what it requires to be disclosed to the patient is determined not by reference to the information a reasonable doctor might disclose, but by reference to the significance a 'prudent patient' would be likely to attach to the disclosure in deciding whether or not to undergo the treatment[131]. Scott J noted that the House of Lords in the *Sidaway* case (Lord Scarman dissenting) declined to adopt the doctrine and instead reaffirmed the 'Bolam' test and said that in his view there was no justification for adopting it in South African law. He said that there could be little doubt that a reasonable doctor from whom advice is sought regarding a 'high risk' prophylactic operation, such as in the present case, would give his patient a full account of the risks involved and quoted Lord Bridge of Harwick in the Sidaway case[132]. But it does not follow, said Scott J, that the doctor is obliged to point out meticulously each and every complication that may arise[133]. He said that to do so could well result in the risk of complications and their possible further *sequelae* assuming an undue and even distorted significance in the patient's assessment of whether to proceed with the operation or not. Scott J held that the doctor is not obliged to educate his patient to the extent of bringing him up to the standard of his own medical knowledge of all the relevant factors involved. What he must do, it is present his patient, in such circumstances, with a fair and balanced

---

130 *Reibl v Hughes* (1980) 114 DLR (3d) 1 (Can SC)

131 *Canterbury v Spence* (1972) 464 F 2d 772

132 *Sidaway* fn 128 *supra* at 502 (WLR) and at 660 (All ER) where he said: "It is clearly right to recognise that a conscious adult patient of sound mind is entitled to decide for himself whether or not he will submit to a particular course of treatment proposed by the doctor, most significantly surgical treatment under general anaesthesia."

133 *Lymbery v Jefferies* fn 33 *supra* at p 240. In this case, Wessels, JA said at p 240: "The next ground of negligence may also be disposed of, viz. that the respondent did not point out clearly the dangers to which the appellant might be exposed from submitting to the X-ray treatment. It was argued that it was negligence on the part of a surgeon or doctor not to inform his patient of the danger of an operation or treatment. It may well be that it is the duty of a surgeon before operating to tell the patient that the operation is dangerous and may end in death, or that it will be accompanied with great pain, and to obtain the patient's consent. In such cases, however, all the surgeon is called upon to do is to give some general idea of the consequences. There is no necessity to point out meticulously all the complications that may arise. Now the evidence of Dr. Stewart, a qualified radiologist and demonstrator in radiography at the Witwatersrand University, is that there is no need to warn a patient of the danger of submitting to X-ray treatment for fibrosis of the uterus because as a rule there is no danger attending this treatment. The evidence shows that burns are rare where the treatment is properly carried out and often due to some idiosyncrasy on the part of the patient which cannot be foretold. I am therefore of opinion that no duty was imposed upon Dr. Jefferies to point out to Mrs. Lymbery that a burn might result from an X-ray treatment for *fibrosis uteri*."

picture of the material risks involved. Scott J examined the evidence of the various claims involving the failure to inform the patient and found that they were without substance. The plaintiff's claim against the defendant failed and judgment was granted in favour of the defendant.

In the appeal against the judgment of Scott J, Ackerman J observed that it has on occasion been suggested that a 'mere error of judgment' on the part of a medical practitioner does not constitute negligence[134] and associated himself with the views of the House of Lords *in Whitehouse v Jordan and Another*[135]. The court pointed out that in *Esterhuizen v Administrator, Transvaal*, Bekker J stated that generally speaking to establish the defence of *volenti non fit injuria* the plaintiff must be shown not only to have perceived the danger, for this alone would not be sufficient, but also that he fully appreciated it and consented to incur it. Indeed if it is to be said that a person consented to bodily harm or to run the risk of such harm, then it presupposes knowledge of that harm or risk. Accordingly, said Bekker J, mere consent to undergo X-ray treatment, in the belief that it is harmless or being unaware of the risks it carries, cannot in my view amount to effective consent to undergo the risk or the consequent harm. Ackermann J also noted that Bekker J was quoted with approval in the judgment of Neser J in *Rompel v Botha*[136].

---

134 He referred to the case of *Whitehouse v Jordan and Another* [1981] 1 All ER 267 (HL) in which the House of Lords inter alia considered the correctness of the statement by Denning MR in the Court of Appeal that: 'We must say, and say firmly, that, in a professional man an error of judgment is not negligence'and noted that the House of Lords held this to be an inaccurate statement of the law. At 281*a* Lord Fraser of Tullybelton expressed the view that: "I think Lord Denning MR must have meant to say that an error of judgment "is not necessarily negligent".'Lord Fraser further observed as follows (at 281b): 'Merely to describe something as an error of judgment tells us nothing about whether it is negligent or not. The true position is that an error of judgment may, or may not, be negligent; it depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that a man, acting with ordinary care, might have made, then it is not negligent."

135 *Whitehouse v Jordan and Another* [1981] 1 All ER 267 (HL)

136 *Rompel* 1953, Transvaal Provincial Division, unreported) in which it was held that "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."

Referring to the judgment of Watermeyer J in *Richter v Estate Hamman*[137], Ackerman J stated that in the passage quoted as (a)[138], Watermeyer J was alluding to the problems surrounding the so-called 'therapeutic privilege' of the medical professional which Giesen *International Medical Malpractice Law*[139] describes as 'designed to permit health care providers to withhold disclosure which they judge would be counter-therapeutic and, thus, "detrimental to a particular patient"'[140]. Ackermann J observed that in an obiter dictum in *SA Medical & Dental Council v McLoughlin*[141], Watermeyer CJ observed that 'it may sometimes be advisable for a medical man to keep secret from his patient the form of treatment which he is giving him'. He noted that the dangers inherent in the so-called therapeutic privilege, and in particular the inroads that it might make on patient autonomy, have been commented on by Van Oosten in his thesis and by Robertson and by Giesen[142]. Ackermann J felt that it was not necessary to further pursue this issue because this so-called privilege was not invoked by the defendant or relied upon in argument to justify a non-disclosure[143]

---

137 *Richter* fn 38 *supra* at p 232 where Watermeyer J held: (a) "A doctor whose advice is sought about an operation to which certain dangers are attached - and there are dangers attached to most operations - is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient's interests to have it." and(b) "It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem. In reaching a conclusion a Court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do. The Court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence."

138 *Richter* fn 38 *supra*

139 Giesen D *Medical Malpractice Law* at p 375

140 Ackerman J also referred the reader to Strauss*Doctor Patient and the Law* 3rd ed at p 10 and p 18-19; Van Oosten FFW *The Doctrine of Informed Consent in Medical Law* (unpublished doctoral thesis, University of South Africa (1989)) at p 423-8; Robertson '*Informed Consent to Medical Treatment*' (1981) 97 *LQR* 102 at p 121-2.

141 *McLoughlin* 1948 (2) SA 355 (A) at 366

142 Mc Loughlin fn 141 *supra*

143 The question of whether informed consent is a contractual issue or not is an interesting one when viewed in the light of the law relating to negligent non-disclosure in the contractual as opposed to the delictual setting. Steyn L 'Damages for Negligent Non-Disclosure By One Contracting Party to The Other' (2003) 120 *SALJ* p465 states that the case of *ABSA Bank Ltd v Fouche* 2003 (1) SA 176 (SCA) merits closer scrutiny in light of the difference in the rationale and the approaches reflected in the majority and minority judgments in this case. It concerned a claim for damages for non-disclosure of information by one contracting party to the other, prior to the conclusion of their contract. Conradie JA, delivering the majority judgment, stated: "It is by now settled law that the test for establishing wrongfulness in a pre-contractual setting is the same as that applied in the case of a non-contractual non-disclosure (*Bayer South Africa (Pty) Ltd v Frost* 1991 (4) SA 559 (A) at 568F - I and 570D - G). In each case one uses the legal convictions of the community as the touchstone (*Carmichele v Minister of Safety and Security and Another* 2001 (1) SA 489 (SCA) at 494E - F applying *Minister of Law and Order v Kadir* 1995 (1) SA 303 (A) at 317C - 318J). The policy considerations appertaining to the unlawfulness of a failure to speak in a contractual context - a non-disclosure - have been synthesised into a general test for liability. The test takes account of the fact that it is not the norm that one contracting party need tell the other all he knows about anything that may be material (*Speight v Glass and Another* 1961 (1) SA 778 (D) at 781H - 783B). That accords with the general rule that where conduct takes the form of an omission, such conduct is prima facie lawful (*BOE Bank Ltd v Ries* 2002 (2) SA 39 (SCA) at 46G - H). A party is expected to speak when the information he has to impart falls within his exclusive knowledge (so that in a practical business sense the other party has him as his only source) and the information, moreover, is such that the right to have it communicated to him 'would be mutually recognised by honest men in the circumstances' (*Pretorius and Another v Natal South Sea Investment Trust Ltd* (under Judicial Management) 1965 (3) SA 410 (W) at 418E - F). Having established a duty on the defendant to speak, a plaintiff must prove the further elements for an actionable misrepresentation, that is, that the representation was material and induced the defendant to enter into the contract."
Steyn observes that while the majority was prepared, not without some hesitation, to treat the information regarding the lack of an alarm and guards as information lying exclusively within the knowledge of the bank officials, it was not, in the circumstances, prepared to hold that an honest person in the position of the bank officials would have thought that

the risk of loss was such that Ms Fouche should know that certain security measures were not in place. Conradie JA explained that by 'honest person' was meant someone embodying the legal convictions of the community, as referred to in *McCann v Goodall Group Operations (Pty) Ltd* 1995 (2) SA 718 (C) at 726A-G. The majority of the court found that the ABSA officials were not under a duty to disclose information about the absence of an alarm and the lack of guards at night. In a dissenting judgment Schutz JA held that not only was there a duty on the part of the ABSA officials to warn Ms Fouche but also that negligence had been proved and that ABSA was consequently liable to Ms Fouche in delict. He explained that in line with the decision in *Bayer South Africa (Pty) Ltd v Frost* 1991 (4) SA 559 (A), a person who induces another to enter into a contract by making a negligent misstatement may not only face the avoidance of the contract but may also be liable to that other for the loss which he suffers in consequence. Not only negligence is required to be established but also unlawfulness which, the learned judge of appeal stated, in the context of this case meant that the plaintiff was required to prove that there was such a duty to speak. Schutz JA explained that whether such a duty existed had to be ascertained by reference to what has been called the legal convictions of the community and he quoted with approval, the principles as summarized in *McCann v Goodall Group Operations (Pty) Ltd*: "From the aforegoing exposition of the law the following principles emerge:

(a) A negligent misrepresentation may give rise to delictual liability and to a claim for damages, provided the prerequisites for such liability are complied with.
(b) A negligent misrepresentation may be constituted by an omission, provided the defendant breaches a legal duty, established by policy considerations, to act positively in order to prevent the plaintiff's suffering loss.
(c) A negligent misrepresentation by way of an omission may occur in the form of a non-disclosure where there is a legal duty on the defendant to disclose some or other material fact to the plaintiff and he fails to do so.
(d) Silence or inaction as such cannot constitute a misrepresentation of any kind unless there is a duty to speak or act as aforesaid.

Examples of a duty of this nature include the following:

(i) A duty to disclose a material fact arises when the fact in question falls within the exclusive knowledge of the defendant and the plaintiff relies on the frank disclosure thereof in accordance with the legal convictions of the community.
(ii) Such duty likewise arises if the defendant has knowledge of certain unusual characteristics relating to or circumstances surrounding the transaction in question and policy considerations require that the plaintiff be apprised thereof.
(iii) Similarly there is a duty to make a full disclosure if a previous statement or representation of the defendant constitutes an incomplete or vague disclosure which requires to be supplemented or elucidated.

These examples cannot be regarded as a *numerus clausus* of the occurrence of a duty to disclose, as may possibly be inferred from the authorities mentioned above. There may be any number of similar factual situations which could give rise to such duty.

In the circumstances Schutz J decided that each requirement mentioned in the 'check-list' in *McCann* had been met. Steyn offers a preliminary observation that this case (*ABSA v Fouche*) indicates just how subjective the application of the notion of the 'legal convictions of the community' actually is. In spite of the fact that in each of the reported judgments exactly the same principles or policy considerations were apparently applied to decide whether the bank officials were under a duty to disclose information about the absence of certain security measures, conflicting decisions were reached. However, analysis and comparison of the judgments, says Steyn, expose more fundamental issues, relating to the requirements for liability for damages in a case of misrepresentation by one contracting party to another, which merit consideration. He points out that in the majority judgment Conradie JA held that to succeed with such a claim, a plaintiff has to prove unlawfulness of the defendant's conduct, in that there was a duty to speak, as well as the further elements for an actionable misrepresentation, that is that the misrepresentation was material and that it induced the defendant to enter into the contract. On the other hand Schutz JA found the bank liable in delict on the basis that its officials' conduct was unlawful as they were under a duty to speak, that their non-disclosure was negligent and that it caused Ms Fouche loss. In other words Schutz JA applied the requirements for Aquilian liability in delict. Steyn asks which of these two approaches is correct? What does the law require to be proved in order to establish liability for damages in such circumstances? He notes that the position was clearly stated by the Appellate Division in Bayer (*supra*) where Corbett CJ delivering the unanimous judgment of the court stated: "In terms of the case of *Administrateur, Natal* [*v Trust Bank van Afrika Bpk* (1979 (3) SA 824 (A))]... a delictual action for damages is available to a plaintiff who can establish (i) that the defendant, or someone for whom the defendant...made a misstatement to the plaintiff; (ii) that in making this misstatement the person concerned acted (a) negligently and (b) unlawfully; (iii) that the misstatement caused the plaintiff to sustain loss; and (iv) that the damages claimed represent proper compensation for such loss...In principle I can see no good reason why in the recognition of such a cause of action based upon a negligent misstatement any distinction should be drawn between a misstatement made which induces a contract and one made outside the contractual sphere....

In principle a negligent misstatement may, depending on the circumstances, give rise to a delictual claim for damages at the suit of the person to whom it was made, even though the misstatement induced such person to enter into a contract with the party who made it. The circumstances will determine the vital issues of unlawfulness and whether there is a causal connection between the making of the misstatement and the loss suffered by the plaintiff."

Steyn states that in light of the above, it is clear that the requirements for delictual liability in terms of the Lex Aquilia – namely (1) unlawful (2) conduct, committed with (3) fault (in the form of intention or negligence) on the part of the defendant, which (4) caused (5) patrimonial loss- must be proved for the plaintiff to succeed in an action for damages in circumstances such as those in *ABSA Bank v Fouche*. He submits that while proof is required that the misrepresentation caused the plaintiff's loss, it is unnecessary for the plaintiff to show, as stated by Conradie JA, that the misrepresentation induced the contract. He further submits that while it is necessary for a contracting party seeking rescission of a contract in the circumstances under discussion, to prove that the misrepresentation was material, this is not a requirement in order to establish liability for damages for loss caused by such misrepresentation. In a health care context, rescission of the contract is of course, unlikely to be an option for most plaintiffs. Steyn states that another aspect of the decision in *ABSA Bank Ltd v Fouche* which deserves further consideration is the test to be applied to determine whether the non-disclosure of the information is unlawful. He notes that Conradie JA explained that the 'legal convictions of the community' must be used as the touchstone and that a party is expected to speak when the information he has to impart falls within his 'exclusive knowledge' and the information is 'such that the right to have it communicate to [the other party] "would be

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

which would otherwise have been actionable. He stated that it does, however, form part of the wider debate concerning consent to medical treatment and whether emphasis should be placed on the autonomy and right of self-determination of the patient in the light of all the facts or on the right of the medical profession to determine the meaning of reasonable disclosure. Ackermann J did not agree with the court *a quo* in its acceptance of the test formulated by Watermeyer J in *Richter v Estate Hamman* to the effect that the "reasonable doctor" test is one which is well-established in South African law and is applied in relation to both medical diagnosis and treatment. It affords the necessary flexibility and if properly applied does not "leave the determination of a legal duty to the judgment of doctors", as suggested by Lord Scarman in *Sidaway v Governors of Bethlehem Royal Hospital and Others*[144] in relation to the so-called "Bolam principle" (*Bolam v Friern Hospital Management Committee*[145]). Ackermann J also did not agree with the conclusion that the 'reasonable doctor' test does not 'leave the determination of a legal duty to the judgment of doctors'. He observed that the 'reasonable doctor' test, insofar as it relates to the standard of disclosure, has received little attention in South African case

---

mutually recognised by honest men in the circumstances" (*Pretorius and Another v Natal South Sea Investment Trust Ltd (under Judicial Management)* 1965 (3) SA 410 (W) at 418E-F). Steyn says that although this is not clearly spelt out, it would appear that Conradie JA regarded the quoted passage as a statement of the general test for liability to which he referred earlier. Steyn submits that it is inappropriate to refer to it as a general test for liability, but rather that this merely describes one of a number of different circumstances in which South African courts have recognized that one contracting party will be under a duty to the other to disclose information. He argues that the position is more accurately set out by Schutz JA in the minority judgment. He raises as a final point that fact that the 'legal convictions of the community are used to determine whether an omission or act is unlawful for the purposes of delictual liability but that on the other hand in the law of contract policy considerations are inherent in the tests which have been specifically developed to determine whether one party may avoid contractual liability on account of the other's failure to disclose certain information before the conclusion of their contract. He asks whether they will always coincide. Can they be equated with one another? Steyn notes that a fundamental difference is that the former considerations are taken into account to limit boundless delictual liability for another's economic loss, in the case of an omission to act, whereas the latter considerations must, as Conradie JA himself mentions, take into account that a contracting party has a right to strike the best bargain for him/herself and is not necessarily obliged to disclose everything s/he knows about anything which may be material. Does this not in itself, he asks, raise the possibility that two sets of considerations do not necessarily accord with one another in all situations?

If the test for the standard of disclosure is that of the reasonable patient, as stated in *Castell*, then this suggests a delictual approach since the patient is simply the ubiquitous reasonable person in the garb of a patient in terms of this test. The failure to obtain informed consent could and in the manner in which the courts have given judgment seems to have fallen more often outside of the contractual sphere than in it. The courts in recent years have shown a general predilection to adjudicate claims based in contract and alternatively in delict on the basis of the latter. The standard of disclosure framed in Castell is a test for unlawfulness since informed consent on the basis of the maxim volenti no fit injuria is a defence against unlawfulness. It is submitted that it is not so different in either effect or principle, from the general test for unlawful non-disclosure referred to by Steyn which is whether the legal convictions of the community require the disclosure. The reasonable patient is likely to entertain the legal convictions of the community in identifying what it is that he or she wants to know. Policy considerations apply in both tests. It is submitted that informed consent does not necessarily have to be a contract or to be governed by the law of contract. It can be a process that precedes a contract for health services in the sense that acts and omissions can precede contracts for other goods and services and it can indeed induce a subsequent contract. In this sense, failure to obtain informed consent can also be seen in the context of a delictual non-disclosure rather than in terms of contract law. If as Steyn points out, in the contractual setting a person is in the eyes of the law entitled to 'strike the best bargain' and is thus not necessarily obliged to disclose everything that he or she knows about that which may be material, then it is submitted that when informed consent is considered against this backdrop it is a concept which belongs rather more in the law of delict than that of contract. As stated previously the bargaining power of the health provider is generally exponentially greater than that of the patient in the health care context.

144 *Sidaway* fn 128 *supra* at p 488 (in WLR, and 649e in All ER)

145 *Bolam* fn 129 *supra*

law and, apart from the above statement of Watermeyer J in *Richter* and Watermeyer CJ's *obiter dictum* in *McLoughlin*, he knew of no firm judicial pronouncement in South Africa to the effect that disclosure is unnecessary because a reasonable doctor faced with the particular problem would not have warned the patient[146]. Ackerman J pointed out that in *Sidaway's* case,[147] Lord Diplock held that:

'. . . To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that the warning may have, is as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on this matter should be treated in the same way. The Bolam test should be applied.'

Lord Diplock was therefore of the view that although the law imposed the duty of care, the standard of care to be enforced was a matter of medical judgment. Ackerman J then referred to the comments of Giesen *Malpractice Law* at p 282[148] and p 284[149]. He noted that after referring to certain passages from the speech of Lord Templeman in this regard, Giesen[150] ventures the view that:

"The understandable fears of Lord Scarman that the majority decision in Sidaway will result in English law developing out of tune with other important common law jurisdictions may thus prove, in final analysis, to be unfounded."

According to Ackermann J, at least one commentator, Simon Lee '*A Reversible Decision on Consent to Sterilisation*'[151] would appear to bear out Lord Scarman's

---

146 Ackermann J also referred to Giesen D 'From Paternalism to Self-Determination to Shared Decision-making' in (1988) *Acta Juridica* 107; Van Oosten (fn 140 *supra*) at 39-53 (in particular, at 50-1)) and Strauss (fn 140 *supra*) at 8-12 and 18-19); See also Dreyer L 'Redelike Dokter versus Redelike Pasiënt' 1995 *THRHR* 532

147 Also reported in *Sidaway v Bethlehem Royal Hospital Governors and Others* [1985] 1 All ER 643 (HL), at 658-9

148 Giesen comments as follows: "One has to consider this result carefully. Should the medical profession really be appointed judge in its own cause? Carried to its ultimate logical conclusion, Lord Diplock's opinion would mean that the function of English Courts would be limited to determining whether the defendant physician had acted in accordance with a responsible body of medical opinion, unless the plaintiff was a member of the judiciary (a reference by Giesen to the singular observation at 659a-b that members of the judiciary have the right to be informed as patients apparently because they are aware of their right of self-determination) or had specifically demanded information which the physician then failed to disclose. A standard of disclosure which allows the medical profession to be judge in its own cause and physicians in deciding what is best for the patient to override the patient's right to decide for himself is "medical imperialism" at its worst. We cannot but agree with Lord Scarman's criticism of that stance."

149 "It is further submitted (i) that insofar as Sidaway could be interpreted as sanctioning the view that expert medical evidence is conclusive, it must be regarded as misguided and against the overwhelming international trend to the contrary; (ii) that in this case Lord Scarman's dissenting opinion would have to be considered preferable to Lord Diplock's judicial interpretation of the majority decision of the House; (iii) but that in fact, this decision, in the light of the opinions expressed by a majority of the Law Lords (Lords Bridge, Keith, Templeman and Scarman) does not sanction the view that expert medical evidence has to be treated as conclusive on the assumption that the standard of disclosure is to be determined exclusively by reference to the current state of responsible and competent professional opinion and practice. The implications of such a view would be disturbing in the extreme. But the Courts do not allow medical opinion with regard to what is best for the patient to override the patient's right to decide for himself whether he will submit to the treatment or not."

150 Giesen fn 139 *supra* at p 284

151 Lee S (1987) 103 *LQR* at p 513

misgivings. In commenting on the Court of Appeal's decision in *Gold v Haringey Health Authority*[152], Lee states the following:

"So the Court of Appeal's decision ignores the main thrust of the judgments in *Sidaway*. I observed at the time (101 LQR 316) that *Sidaway* should not be treated as informed consent (Lord Scarman) 1, uninformed consent 4. There is plenty of material in the speeches of Lord Bridge, with whom Lord Keith agreed, and Lord Templeman to incline a subsequent Court towards the view favoured by Lord Scarman rather than the other extreme favoured by Lord Diplock. In concentrating on Lord Diplock's judgment to the exclusion of the others, the Court of Appeal has threatened to stop the development of a coherent doctrine of consent."

Ackermann J rejected the view of Scott J in the court *a quo* that there can be no justification for the adoption of the doctrine of informed consent in South African law[153]. He said he was constrained to disagree, inasmuch as he was of the view that there was not only a justification, but indeed a necessity, for introducing a patient-orientated approach in this connection. In his view it was important to bear in mind that in South African law (which differs in this regard from English law) consent by a patient to medical treatment is regarded as falling under the defence of *volenti non fit injuria*, which would justify an otherwise wrongful delictual act[154]. Ackermann J held that it is clearly for the patient to decide whether he or she wishes to undergo the operation, in the exercise of the patient's fundamental right to self-determination. A woman may be informed by her physician that the only way of avoiding death by cancer is to undergo a radical mastectomy. This advice may reflect universal medical opinion and may be, in addition, factually correct. Yet, to the knowledge of her physician, the patient is, and has consistently been, implacably opposed to the mutilation of her body and would choose death before the mastectomy. He said he could not conceive how the "best interests of the patient" (as seen through the eyes of her physician or the entire medical profession, for that matter) could justify a mastectomy or any other life-saving procedure which entailed a high risk of the

---

152 *Gold* [1987] 2 All ER 888 (CA) at p 515

153 *Scott* J stated at p 518 of the judgment in the court *a quo*: "Mr Oosthuizen invited me to adopt, if not in its entirety, certain aspects of the doctrine of "informed consent". This doctrine originated in certain jurisdictions of the United States of America and has been accepted in modified form by the Supreme Court of Canada (*Reibl v Hughes* (1980) 114 DLR (3d) 1 (Can SC). The doctrine holds that a patient's consent to medical treatment is vitiated if he is given inadequate information concerning the proposed treatment and that, subject to certain exceptions, what it requires to be disclosed to the patient is determined not by reference to the information a reasonable doctor might disclose, but by reference to the significance a "prudent patient" would be likely to attach to the disclosure in deciding whether or not to undergo the treatment (*Canterbury v Spence* (1972) 464 2d 772). The House of Lords in the *Sidaway* case (Lord Scarman dissenting) declined to adopt the doctrine and instead reaffirmed the "Bolam" test. In my view there can be no justification for adopting it in our law." It was this specific passage in his judgment to which Ackerman J objected.

154 In this regard Ackermann J referred *to inter alia, Stoffberg v Elliott* (fn 14 *supra*) at p 149-50; *Lymbery v Jefferies* fn 33 *supra* at p 240; *Lampert v Hefer NO* 1955 (2) SA 507 (A) at p 508; Esterhuizen's case fn 4 *supra* at p 718-22; Richter's *Richter* fn 38 *supra* at 232 and *Verhoef v Meyer* 1975 (TPD) and 1976 (A) (unreported), discussed in Strauss (fn 29 *supra* at p 35-6).

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

patient losing a breast. Even if the risk of breast-loss were insignificant, a life-saving operation which entailed such risk would be wrongful if the surgeon refrains from drawing the risk to his patient's attention, well knowing that she would refuse consent if informed of the risk. Ackermann J stated that it is, in principle, wholly irrelevant that her attitude is, in the eyes of the entire medical profession, grossly unreasonable, because her rights of bodily integrity and autonomous moral agency entitle her to refuse medical treatment. It would, in his view, be equally irrelevant that the medical profession was of the unanimous view that, under these circumstances, it was the duty of the surgeon to refrain from bringing the risk to his patient's attention. In this regard Ackermann J referred extensively to Giesen[155] and he also referred to a passage from the thesis of Van Oosten[156]. Ackermann J then went on to refer to two leading

---

155 Giesen fn 139 *supra*, after drawing attention (at p 289) to the fact that 'an increasing number of both common and civil law jurisdictions' (as diverse as Canada, the United States, France, Germany and Switzerland) have moved away from 'professional standards of disclosure' to more 'patient-based' ones, points out (at 297) that there are two patient-based standards that could be applied:

'(i) the "objective" or "reasonable" patient standard, posited on the informational requirements of the hypothetical "reasonable" patient in what the physician knows or should know to be the patient's situation, or

(ii) the individual or "subjective" patient standard, whereby the physician must disclose information which he knows, or ought to know, that his particular patient in his particular situation requires'.

Giesen proposes (at p 303-5) a 'blending' of the reasonable patient 'minimum' with the individual patient 'additional needs test'. Giesen (ibid) sees no objection to using the 'reasonable patient' test as the point of departure. 'It will normally lead the physician to a correct assessment of the average patient's minimum informational needs. His right to self-determination does not require more if in fact the individual patient is a member of that community of reasonable (or "model") patients with average informational needs.' Ackermann J noted that this approach must, however, 'be supplemented by a more subjective patient-based standard, better attuned to the values of each person and his or her inalienable right of self-determination, and better able to manage situations beyond the limitations of the objective test'. Giesen argues (at 304) that the 'right of the patient to make his own decision about what is to be done with his own body' must be guaranteed 'even where the individual patient differs from what the medical profession or anyone else considers to be a "reasonable" patient. The patient has a right to be different. The patient has a right to be wrong.' He concludes (at p 305) by quoting with approval the following passage from *McPherson v Ellis* 287 SE 892 (NC 1982), a North Carolina Supreme Court decision in which the subjective test was adopted as a supplement to the prevailing objective test: 'In determining liability by whether a reasonable person would have submitted to treatment had he known of the risk that the defendant failed to relate, no consideration is given to the peculiar quirks and idiosyncrasies of the individual. His supposedly inviolable right to decide for himself what is to be done with his body is made subject to a standard set by others. The right to base one's consent on proper information is effectively vitiated for those with fears, apprehensions, religious beliefs, or superstitions outside the mainstream of society.'

Giesen, at p 294, comments that: 'Judicial attitudes which stress the primacy of the patient's right to self-determination prevail . . . also in civil law traditions on this (i.e. the European) side of the Atlantic, at least those with a more developed body of case law . . . . In Civil Law countries, risk-disclosure standards set by the courts prevail to the exclusion of traditional professional standards of disclosure, particularly so in jurisdictions which emphasise the individual's right to freedom from non-consensual invasion of such interests (mostly delict-protected) as bodily integrity.' Of great interest too are his particular comments (at p 295) on German and Swiss law: 'Both legal systems take as their starting point the patient's human right to decide for himself what shall be done to his body, and this principle is in no way reduced or limited by considerations which would allow the medical profession to override the patient's own will with paternalistic views of what is best for him. The duty of disclosure exists to ensure that the patient can make an informed decision, in the words of the Swiss Federal Court, en connaissance de cause. This implies that the patient, on the one hand, is aware of the possible consequences of the proposed medical procedure, its risks and possible side-effects and, on the other hand, that he retains his absolute discretion, in the knowledge of his entire situation, to make a decision of his own - even if this decision is one which others (such as the medical profession or a responsible body of medical opinion in the *Maynard* or *Sidaway* sense) would consider to be inappropriate ('verfehlt'), unreasonable ('unvernünftig'), or untenable ('unvertretbar').'

156 Van Oosten fn 140 *supra* where he states at p 414 of his thesis: "When it comes to a straight choice between patient autonomy and medical paternalism, there can be little doubt that the former is decidedly more in conformity with contemporary notions of and emphasis on human rights and individual freedoms and a modern professionalised and consumer-orientated society than the latter, which stems largely from a bygone era predominantly marked by presently outmoded partriarchal attitudes. The fundamental principle of self-determination puts the decision to undergo or refuse a medical intervention squarely where it belongs, namely with the patient. It is, after all, the patient's life or health that is at stake and important though his life and health as such may be, only the patient is in a position to determine where they rank in his order of priorities, in which the medical factor is but one of a number of considerations that influence his decision whether or not to submit to the proposed intervention. But even where medical considerations are the only ones

decisions of the Australian Courts of the standards of disclosure required of a doctor in treating a patient, namely *F v R*[157], a decision of the Full Court of the Supreme Court of South Australia and *Rogers v Whitaker*[158], a decision of the High Court of Australia. In both cases the matter was approached on the basis of the doctor's duty of care to the patient, breach of which would constitute negligence on the doctor's part. Ackermann J pointed out that the matter is approached somewhat differently in South African law, the enquiry being whether the defence of *volenti non fit injuria* has been established and in particular whether the patient's consent has been a properly informed consent. He observed that on either approach the same, or virtually identical, matters of legal policy are involved[159]. Ackermann J supported the view of King J in *F v R*[160] that the ultimate question is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standards of reasonable care demanded by the law. That is a question for the Court and the duty of deciding it cannot be delegated to any profession or group in the community. Ackermann J observed that in *Rogers v Whitaker* Mason CJ and Brennon J, Dawson J, Toohey J and McHugh J in a joint judgment trenchantly criticised the so-called 'Bolam principle' and its application in *Sidaway* and quoted its formulation by Lord Scarman in that case at p 48 to 49[161]. He noted out that the court in this case

---

that come into play, the cardinal principle of self-determination still demands that the ultimate and informed decision to undergo or refuse the proposed intervention should be that of the patient and not that of the doctor."

157 *F* (1983) 33 SASR 189

158 *Rogers* (1993) 67 ALJR 47

159 He quoted from the judgment of King CJ in *F v R* at p 191 to illustrate this commonality: "Determination of the scope of the doctor's duty to disclose involves consideration of two values which are sometimes in conflict, namely the duty of the doctor to act in what he conceives to be the best interests of the patient and the right of the patient to control his own life and to have the information necessary to do so. The decided cases in England have tended to place the emphasis on the former value and in consequence to formulate the test of negligence largely, and sometimes exclusively, in terms of the extent of disclosure required by the practice prevailing in the medical profession . . In the United States, and to some extent in Canada, there is a tendency to place greater weight on the patient's right to receive the information which is necessary for an informed decision as to whether to undergo the proffered treatment, that is to say on what is often termed in the United States "the right of self-determination", eg *Canterbury v Spence* ((1992) 464 F (2d) 772); *Reibl v Hughes* ((1980) 114 DLR (3d) 1)." and at p 193-4: "Finally the question must be: "Has the doctor in the disclosure or lack of disclosure which has occurred, acted reasonably in the exercise of his professional skill and judgment, or, as Bristow J put it in *Chatterton v Gerson* ([1981] 1 All ER 257), in the way a careful and responsible doctor in similar circumstances would have done?" In answering that question much assistance will be derived from evidence as to the practice obtaining in the medical profession. I am unable to accept, however, that such evidence can be decisive in all circumstances: *Goode v Nash* ((1979) 21 SASR 419 (FC)). There is great force in the following passage from the judgment of the Supreme Court of Canada in *Reibl v Hughes* ((1980) 114 DLR (3d) 1 at 13):'To allow expert medical evidence to determine what risks are material and, hence, should be disclosed and, correlatively, what risks are not material is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there had been a breach of that duty. Expert medical evidence is, of course, relevant to findings as to the risks that reside in or are a result of recommended surgery or other treatment. It will also have a bearing on their materiality but this is not a question that is to be concluded on the basis of the expert medical evidence alone. The issue under consideration is a different issue from that involved where the question is whether the doctor carried out his professional activities by applicable professional standards. What is under consideration here is the patient's right to know what risks are involved in undergoing or forgoing certain surgery or other treatment.'"

160 *F v R* fn 157 *supra*

161 *Rogers* fn 158 *supra* "The Bolam principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of

pointed out that in Australia, particularly in the field of non-disclosure of risk and the provision of advice and information, the Bolam principle has been discarded and, instead, the courts have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to "the paramount consideration that a person is entitled to make his own decisions about his life". Ackermann J considered the criticism by the Australian court in *Rogers* of the terms 'the patients right of self-determination' and 'informed consent' as used by the American authorities[162]. Ackermann J held that for consent to operate as a defence the following requirements must *inter alia* be satisfied:

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

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

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

(d) the consent must be comprehensive, that is extend to the entire transaction, inclusive of its consequences'.

He held with regard to the criticism in *Rogers v Whitaker*[163] of the expression "informed consent" that the position in South African law is quite different and the

---

medical judgment." The Court in *Rogers v Whitaker* (fn 158 *supra* at p 50) indicated the following shortcoming in the Bolam approach as applied in Sidaway: "One consequence of the application of the Bolam principle to cases involving the provision of advice or information is that, even if a patient asks a direct question about the possible risks or complications, the making of that inquiry would logically be of little or no significance; medical opinion determines whether the risk should or should not be disclosed and the express desire of a particular patient for information or advice does not alter that opinion or the legal significance of that opinion. The fact that the various majority opinions in Sidaway, for example, suggest that, over and above the opinion of a respectable body of medical practitioners, the questions of a patient should truthfully be answered (subject to the therapeutic privilege) indicates a shortcoming in the Bolam approach. The existence of the shortcoming suggests that an acceptable approach in point of principle should recognise and attach significance to the relevance of a patient's question."

162 The criticism of the former expression was on the basis that, while perhaps suitable 'to cases where the issue is whether a person has agreed to the general surgical procedure or treatment', it was of little assistance in 'the balancing process that is involved in the determination of whether there has been a breach of the duty of disclosure'. This criticism struck Ackerman J as being "somewhat paradoxical" when regard is had to the court's own endorsement of 'the paramount consideration that a person is entitled to make his own decisions about his life'. In any event, said Ackerman J, it did not seem to be appropriate when applied to the position in South African law, where the issue is treated not as one of negligence, arising from the breach of a duty of care, but as one of consent to the injury involved and the assumption of an unintended risk. He said that in the South African context the doctor's duty to disclose a material risk must be seen in the contractual setting of an unimpeachable consent to the operation and its sequelae (see *Van Wyk v Lewis* fn 3 *supra* at 451; *Correira v Berwind* [fn 47 *supra*] at p 63 and *Verhoef v Meyer* (supra at 32 et seq of the unreported Transvaal Provincial Division judgment and p 26-9 of the unreported Appellate Division judgment)). He referred with approval to the statement of Van Oosten (fn 140 *supra*) that: "South African law generally classifies *volenti non fit* injuria, irrespective of whether it takes the narrower form of consent to a specific harm or the wider form of assumption of the risk of harm, as a ground of justification (regverdigingsgrond) that excludes the unlawfulness or wrongfulness element of a crime or delict."

163 *Rogers* fn 158 *supra*. The criticism was to the effect that ". . . consent is relevant to actions framed in trespass, not in negligence. Anglo-Australian law has rightly taken the view that an allegation that the risks inherent in a medical procedure have not been disclosed to the patient can only found an action in negligence and not in trespass. . ."

expression is an appropriate one. Ackermann J stressed as being of particular importance the conclusion of the court in *Rogers* that:

"The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege."

He said that this test bears a very close resemblance to the blending of the 'reasonable patient' minimum with the individual patient 'additional needs test' proposed by Giesen and held that the above formulation laid down in *Rogers v Whitaker*, suitably adapted to the needs of South African jurisprudence, should be adopted in South Africa. In the view of Ackermann J it is "in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving". He noted that this formulation also sets its face against paternalism, from many other species whereof South Africa "is now turning away" and that it is in accord with developments in common law countries like Canada, the United States of America and Australia, as well as judicial views on the continent of Europe. Ackermann J ruled that the majority view in Sidaway must be regarded as out of harmony with medical malpractice jurisprudence in other common law countries. He concluded that in South African law, for a patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment; a risk being material if, in the circumstances of the particular case: a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This obligation is subject to the therapeutic privilege, whatever the ambit of the so-called 'privilege' may today still be.

Ackermann J observed that expert medical evidence would be relevant to determine what risks inhere in or are the result of particular treatment (surgical or otherwise) and

might also have a bearing on their materiality but, in the words of the Supreme Court of Canada in *Reibl v Hughes*[164]:

"this is not a question that is to be concluded on the basis of expert medical evidence alone". The ultimate question, as King CJ stated in *F v R*, is "whether (the defendant's conduct) conforms to the standard of reasonable care demanded by the law. That is a question for the Court and the duty of deciding it cannot be delegated to any profession or group in the community."

Ackermann J then turned to the facts and found that Scott J was clearly correct in finding that defendant had mentioned to plaintiff the repositioning of the areolae and that she had agreed to it. He said that apart from denying that he gave an undertaking that the plaintiff would not, as a consequence of the operation, suffer any loss of sensation in her areolae or nipples, the defendant's evidence was undisputed that the inevitable consequence of a subcutaneous mastectomy is total loss of sensation in these areas. It was, said Ackermann J, in the highest degree unlikely that defendant would have given an undertaking that was impossible of fulfilment. He noted that according to the defendant, he explained to plaintiff that the operation was not one to be embarked on lightly and that there were many complications involving, inter alia, physical complications in respect of her breasts. He says he specifically mentioned to her that the dominant blood supply, which passes through the breast tissue, would be completely removed and that consequently the risk of complications of damage to the skin was very great. He also mentioned to her that complications of infection and bleeding could occur. It was not suggested by the plaintiff, nor seriously contended on her behalf, that as an intelligent lay person she was ignorant of the fact that a compromised blood supply could lead to permanent damage of skin and tissue (including her areolae). Ackermann J held that in the circumstances, Scott J was fully warranted in his finding that the plaintiff was aware of the risks involved in the transposition of her areolae. Ackerman J found that here was no merit in the complaint that plaintiff was allowed to labour under the misapprehension that the repositioning of her areolae was prophylactically essential and not merely cosmetic. At no stage did plaintiff indicate that she was unaware of the true position in this regard. He said it was difficult to see how she could have been. The purpose of the operation was to remove as much of the breast tissue as possible in order to provide a

164 *Reibl* fn 130 *supra*

prophylaxis against cancer in the future. This plaintiff was aware of. The repositioning of the nipples could not be thought to further this end. In his view Scott J was correct in concluding that the evidence was insufficient to establish that the particular type of subcutaneous mastectomy and prosthesis insertion practised by the defendant involved a materially higher risk than if a two-stage procedure was used. Ackermann J also upheld Scott J's conclusions concerning the allegations of post operative negligence on the part of the defendant. He found that the expert evidence plaintiff fell far short of proving, on a balance of probability, that defendant was negligent in not taking the steps indicated. In the view of Ackermann J the plaintiff had proved on a clear balance of probability:

(a) that she developed post-operative sepsis in her breasts which manifested itself no later than 14 August and became systemic and continued to be systemic until at least 24 August;

(b) that defendant became aware of this sepsis on 16 August; and
that the organism, or one of the organisms, causing such sepsis was resistant to the antibiotics which had been prophylactically prescribed by defendant for plaintiff.

He observed that on the facts as found, defendant was therefore negligent in not following such a procedure when he suspected infection on 16 August. A swab was only taken 12 days later. Had the swab been taken on 16 August, the appropriate antibiotic would have been prescribed and the infection effectively treated that much sooner. He said that the final important question is to determine what causal role defendant's negligent failure in this regard played in the sequelae suffered by plaintiff and the consequent damage sustained by her. Ackermann J found that the necrosis suffered by plaintiff in her breast had become irreversible not later than 48 hours after the operation, i.e. by the evening of 9 August, and certainly well before any infection set in or could reasonably be diagnosed. As found, he said, the defendant cannot be held liable in law for the sequelae of the necrosis. It was clear that the necrosis was at least the predominant and major cause of the restorative and reconstructive surgery and medical treatment, for the plaintiff's subsequent periods in hospital and for the pain, discomfort and other trauma suffered by plaintiff in consequence thereof. It was impossible, on the evidence, to establish that defendant's negligence in failing to treat the infection timeously and properly played any role at all in the harm ultimately suffered by plaintiff. Ackermann J held that it certainly was not sufficiently causally

connected therewith in the sense mentioned in *Blyth v Van den Heever*[165]. Ackermann J held that the best that could be done, under the circumstances, was to compensate plaintiff for the additional period of pain, suffering, illness, discomfort and anxiety she had to endure because of the defendant's failure to treat her infection properly and timeously. This period was fairly represented by the period of delay in taking the swab for microbiological testing. This was a period of 12 days. In his view a sum of R7 500 would fairly and adequately compensate plaintiff in this regard.

Ackermann J ruled that the appeal accordingly succeeded with costs.

Discussion

Informed consent is about patient autonomy and the right of self-determination. As such, it is submitted that it is a doctrine that is entirely in keeping with the values and principles within the South African Constitution. However long before the decision in *Castell* the maxim *volenti non fit iniuria* has yielded a defence of consent to intended harm in South African law[166]. Boberg observes that consent freely and lawfully given by a person who has the legal capacity to give it justifies the conduct consented to, making lawful the infliction of the ensuing harm. It is therefore a defence that operates by negativing unlawfulness[167]. Why then was it specifically necessary for the court in *Castell* to recognize a doctrine of informed consent? Is the latter wider than

---

165 *Blyth* fn 42 *supra* at p 208A and p 223C-G

166 For example in *Stoffberg v Elliott* (fn 14 *supra*) and *Esterhuizen v Administrator Transvaal* (fn 3 *supra*).

167 Boberg (fn 20 *supra*) p 724. He notes, however, that modern law has grafted another limb onto the *volenti* principle which, it is generally agreed has 'bred a nest of troubles'. Variously called 'voluntary assumption of risk' and 'consent to risk of harm' this concept, he says, conveys the notion that a person who willingly encounters a known and appreciated danger forfeits any right to compensation if the risk materialises to cause him harm. Precisely why this should be so, says Boberg, is not clear. He says that most writers seem to see it simply as an extension of the volenti principle to liability based on negligence. Since Aquilian liability can arise from intention or negligence a sense of symmetry engenders the belief that *volenti non fit injuria* should exclude responsibility on either basis, consent condoning harm caused intentionally, voluntary assumption of risk excusing harm caused negligently. He states that not all the implications of this approach are acceptable. Boberg notes that undeterred by jurisprudential qualms South African courts have repeatedly affirmed the existence of the defence of voluntary assumption of risk and endorsed Innes CJ's summary of its requirements in *Waring & Gillow v Sherbourne* 1904 TS 340. However, its theoretical foundation received short shrift in earlier decisions and even the Appellate Division in *Lampert v Hefer NO* 1955 (2) SA 507 (A) avoided assigning it a definite juridical niche. Nor says Boberg was it then necessary to separate voluntary assumption of risk from contributory negligence for both were complete defences. Boberg notes that the belief that a person should be entitled to encounter a danger without losing his right against a party negligently responsible for creating it – in other words that factual assumption of risk should not be equated to legal assumption of risk – finds expression in the bargain theory associated with Glanville Williams. The latter requires 'an express or implied bargain between the parties whereby the plaintiff gave up his right of action for negligence. Boberg notes that Glanville Williams says that to dispense with this 'is to ignore the chain of cases deciding that knowledge is not tantamount to consent. Consent, in modern law, means agreement, and it would be much better if the latter word replaced the former'. Boberg notes that acceptance of the bargain theory makes consent indistinguishable from waiver. He states that unfortunately this approach seemed to the Appellate Division to place 'an unduly heavy onus upon the defendant and...not to accord with the general term of our own decisions'. In rejecting it, the court committed our law to the equation of factual with legal acceptance of a foreseen risk. Nor, says Boberg does the court's criterion of consent give proper effect to the subjective character of the volenti defence that the court itself insisted upon. For it is not really a subjective test of *consent* at all: it is a subjective test of *foresight* which , once established, is deemed objectively to amount to consent.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

the principle *volenti non fit injuria*?[168] In the judgment of the court in *Castell*, Ackermann J found that whereas in English (and Australian) law the issue of consent to medical treatment is approached on the basis of the doctor's duty of care to the

---

168 Van Oosten FFW in 'Castell v De Greeff and the Doctrine of Informed Consent: Medical Paternalism ousted in favour of Patient Autonomy' 1995 *De Jure* 164-179 states: "Ordinarily, lawful consent is out of the question unless the consenting party knows what it is he consents to. Since the patient is usually a layman in medical matters, knowledge and appreciation on his part can only be effected by appropriate information. In this way, adequate information becomes a requisite of knowledge and appreciation and, therefore, also of lawful consent. In the absence of information, real consent will be lacking. In turn this means that the informed consent requisite saddles the doctor, as an expert, with a corresponding legal duty to provide the patient with the necessary information to ensure knowledge and appreciation and hence, real consent on the patient's part." He notes that the informed consent requisite has met with strong resistance in medical quarters. This is particularly borne out by the multitude of paternalistically inclined objections voiced by the medical profession against the doctor's duty of disclosure. Van Oosten observes that while it may be true that the doctor is medically in the best position to judge the necessity or desirability of an intervention, considerations other than medical ones are often also relevant to the patient's decision to undergo or refuse an intervention. Such considerations, he says, fall outside the doctor's scope of competence. But even, he say, where medical considerations are the only ones, the ultimate decision to undergo or forego a medical intervention should rest with the patient as master of his own body and life and not with the doctor. Moreover the doctor's duty to heal is not absolute but relative. Van Oosten hails *Castell* as a landmark in South African medical law in general and the law of consent to medical interventions in particular. He says it not only espouses some new principles but also reinforces in sometimes stronger terms than before already existing ones. Firstly, he says, the court clearly opted for patient autonomy over medical paternalism and shifted the emphasis from a medical professional standard of disclosure to a patient autonomy standard of disclosure. He observes that prior to Castell, the courts while accepting and recognising a duty to inform on the doctor's part seemed to vacillate between them conflicting notions of the patient's right to self-determination and on the one hand and the reasonable doctor test on the other. Secondly, he notes that the court rightly proceeded from the assumption that the decision to undergo or refuse a medical intervention is, in the final analysis, that of the patient and not that of the doctor and that the court's stance is logically consistent insofar as the right to refuse and the right to consent to medical interventions are the reverse sides of the same coin. Thirdly, says van Oosten, in terms of the 'material risk' standard of disclosure espoused by the court, the question is apparently no longer whether or not the medical profession assesses the risk or danger as serious or typical or unusual or remote or whether or not the reasonable doctor would have disclosed the risk or danger in question. Instead the question is now whether or not the reasonable patient would have regarded the risk or danger as significant, or whether or not the doctor was or could have been aware that the individual patient would regard the risk or danger as significant. He says the shift in emphasis from a professional-oriented test of disclosure to a patient oriented test of disclosure represents a radical departure from existing law and an important judicial innovation in the sphere of the doctor's duty to inform. Fourthly, states van Oosten, although the court gave recognitions to the so-called 'therapeutic privilege' its approach to the defence is to some extent ambivalent. On the one hand the court appears to accept that therapeutic privilege sets a limit to the doctor's duty of disclosure while on the other it seems to associate the defence with medical paternalism. He observes that it can hardly be denied that the term 'therapeutic privilege' is less than fortunate insofar as it implies a professional discretion to forego disclosure and hence contains an element of medical paternalism. At the same time, he states, it is equally true that a definite need for a legal defence to non-disclosure exists in cases where the harm caused by the disclosure would outweigh the harm caused by the non-disclosure. Van Oosten comments that the obvious and appropriate legal defence in this context is necessity as a justification. He says that not only is necessity as a justification designed to resolve conflicts of interests but it is also one of the recognised and accepted defences to non-consensual medical interventions in emergency situations.
Fifthly, says van Oosten, the court prefers to place the doctor's duty of disclosure and its concomitant, the patient's informed consent, within the framework of the wrongfulness element (with *volenti non fit injuria* or voluntary assumption of the risk of harm as a justification) rather than the fault element of delict. Sixthly, Van Oosten states that insofar as the court's remarks appear to suggest that the doctor is also under a contractual obligation to furnish the patient with information they raise some points of interest. Does this mean that at least for purposes of contracts between doctors/hospitals and patients, the patient's consensus is synonymous with or equivalent to volenti non fit injuria? If so, must the patient's consensus comply with the requirements of *volenti non fit injuria* to qualify as valid? If so is the doctor's duty of disclosure one of the naturalia or a tacit term of the contract between the doctor/hospital and patient? If so, are the patient's personality rights of "bodily integrity" and "autonomous agency" by implication also afforded contractual protection? Van Oosten states that if this is what the courts remarks add up to, contractual protection of the patient's personality rights would nevertheless be incomplete since breach of contract on the doctor's part which violates the patient's personality rights would entitle the latter to no more than an award of pecuniary damages. If non-disclosure were to result in a non-consensual medical intervention which violates that patient's personality rights without causing him patrimonial loss, his remedies would be restricted to a delictual action for sentimental damages or a charge of criminal assault or injuria. According to van Oosten, this is not to say that breach of contract may not in specific circumstances constitute an appropriate cause of action. Where a patient specifically contracts with a doctor for disclosure of the diagnosis or for the disclosure of all of the consequences and complications of and alternatives to the proposed intervention, and the doctor fails to keep his side of the bargain, contractual liability for patrimonial loss is quite conceivable. Lastly, he says, the court appears to have introduced the patient's right to self-determination or freedom of choice as a new category of personality rights into South African medical law and wider than the right to physical integrity. He cites as an example the taking of a doctor of blood or tissue samples without the patient's informed consent and notes that it amounts to a violation of the patient's right to privacy or freedom of choice but not to a violation of his bodily integrity. He notes that since liability for civil and/or criminal assault would be out of the question in these instances the patient's recourse would seem to lie in civil and/or criminal injuria as the most obvious currently existing delict and crime under which such a new category of personality rights can be accommodated.

patient, the breach of which would constitute negligence on the doctor's part, in South African law it is treated as falling under the defence of *volenti non fit injuria,* the enquiry being whether the said defence has been established and, in particular, whether the patient's consent has been a properly informed consent. However, on either approach the same, or virtually identical, matters of legal policy are involved. Later on in the judgment Ackermann J states once again that: "It is important, in my view, to bear in mind that in South African law (which would seem to differ in this regard from English law) consent by a patient to medical treatment is regarded as falling under the defence of *volenti non fit injuria*, which would justify an otherwise wrongful delictual act."

Ackermann J stated that in any event, it did not seem to be appropriate when applied to the position in South African law, where the issue is treated not as one of negligence, arising from the breach of a duty of care, but as one of consent to the injury involved and the assumption of an unintended risk. In the South African context the doctor's duty to disclose a material risk must be seen in the contractual setting of an unimpeachable consent to the operation and its sequelae (see *Van Wyk v Lewis*[169]; *Correira v Berwind*[170]). It is submitted that this is simply an endorsement of the principle of *volenti nonfit injuria* since these cases were decided long before any debate concerning informed consent. From the passage quoted above, the question of whether the standard of disclosure should be that of the reasonable doctor or the reasonable patient did not seem to be a point of difference between the principles of *volenti non fit injuria* and informed consent either according to Ackermann J. The appeal court therefore disagreed with the court *a quo* essentially on only one point of law[171] – the standard of disclosure. Scott J's refusal to acknowledge aspects of the doctrine of informed consent appears to have been linked directly to his preference for the reasonable standard of disclosure and so this is not a second point of difference between his decision and that of Ackermann J. It is consequently submitted that the doctrine of informed consent in South African law is essentially just another term for the application of the maxim *volenti non fit injuria* and that the main issue that was

169 *Van Wyk* fn 3 *supra* at p 451

170 *Correira* fn 47 *supra* at p 630

171 Ackermann J disagreed with Scott J on only one small factual aspect of the case, namely that there was an undue delay on the part of the defendant in sending a swab for microbiological testing resulting in an additional period of pain, suffering, illness, discomfort and anxiety that she had to endure and for which the court considered R7 500 was adequate compensation.

clarified or settled in *Castell* was nature of the standard of disclosure to be used in obtaining informed consent.

Strauss, writing before the decision in *Castell v de Greef*, points out that knowledge and appreciation are the two basic elements of consent[172]. He notes that in our time, patient autonomy – the right to self-determination as opposed to the traditional attitude of medical paternalism- is increasingly emphasised by lawyers and doctors alike. The judgment of Ackermann J in *Castell* was clearly looking to the provisions in the constitutional Bill of Rights although at the time when the claim arose, the Constitution was still in its infancy. Strauss maintains that legally here would ordinarily be no duty upon the doctor to inform the patient fully of the diagnosis. He says that the diagnosis concerns the question 'why?' and may be based on a complexity of symptoms and involve some scientific assessment of the case on the basis of the doctor's knowledge, skill and experience. Strauss observes that it may be impractical to attempt giving the patient in layman's language, a general indication of the diagnosis and that the full diagnosis must generally be given only where the patient stipulates this as a condition to giving his consent to an operation or treatment. It is submitted that the question of disclosure of a diagnosis should rather be approached from the perspective of whether there is a good reason to withhold a diagnosis from a patient. If there is no such reason, the diagnosis should be shared with the patient along with other relevant information[173]. This approach is more

---

172 Strauss fn 29 *supra* at p 8

173 Cultural issues can impact significantly upon attitudes to informed consent. Annas, G J and Miller F H 'The Empire of Death: How Culture and Economic Affect Consent in the US, the UK and Japan', ***American Journal of Law and Medicine*** Vol XX No 4 1994 discuss an interesting theory that the content and style of imparting medical information can profoundly affect a country's total health expenditure. They explore the cultural role and the economic impact of telling patients about what doctors actually know – or don't know- about their medical conditions and about therapy that might help (but could also harm) them. They note that initially in the IS, judicial opinions described the requirement of consent to medical treatment as necessary to avoid the intentional tort of battery but by the 1970s courts had begun to reformulate the physician's duty to inform as a negligence concept, required by the fiduciary nature of the doctor-patient relationship. Doctors had been telling patients relatively little and informed consent became recognised as necessary to promote 'shared decision-making'. They note that it soon became not only a legal doctrine promoting self-determination but a core ethical principle as well. Informed consent requirements implement the fundamental principle that 'adults are entitled to accept or reject health care interventions on the basis of their own personal values and in furtherance of their personal goals'. They observe that in the US informed consent is well entrenched in theory but in practice patient autonomy continues to be elusive for many reasons. First, patients (particularly seriously ill ones) remain abjectly dependent on their physicians, who still make choices for them because of the information inequality between doctor and patient. It has been estimated that more than 70 percent of all expenditures for personal health care are the result of decisions of physicians. Moreover, say the authors, the way in which physicians impart information influences patient choice. For example patients tend to go along with therapy their physicians recommend when probably outcomes are discussed in terms of survival percentages, but reject it when those very same outcomes are presented in terms of death statistics. Secondly, state the authors, although the US has a capitalistic, market-driven economy and views medicine as a private good, public expenditure on health care accounts for more than forty percent of the approximately one trillion dollars that Americans will spend on health care in 1995. They note that financial incentives in the system may overwhelm the legal pressure to inform patients adequately. In commenting on his study suggesting that fully half of the coronary angiograms done in the US are unnecessary, Thomas B Graboys explained the difficulties cardiologists have in exploring diagnostic and treatment options with their patient and concluded thus – "It is [just] easier to say we will do

consistent with the patient's rights to human dignity, self-determination and autonomy[174]. The list of complaints by the medical profession against informed consent includes the following-

- It wastes valuable time that could be spend rendering treatment to the ill, in part because patients do not understand what they are told and in part because they do no want to be informed;
- It undermines the trust which patients need to repose in their doctors if they are to be successfully treated;
- It requires disclosure of information about the possibility of risks of induced treatment or failure of the treatment that may lead to a psychologically self-fulfilling prophecy.
- The goal of disclosure of information to patients – that they may make their own choice about treatment – is illusory because disclosure can (and indeed usually will) be made by the physician in such as way as to assure that the patient agrees to the treatment
- For some patients the disclosure of information needlessly frightens them, possibly to the extent that they refuse necessary treatment.
- Some patients have already made up their minds before they acquire the information that the informed consent doctrine requires and the receipt of the information does not change their decision[175].

The individual's right of self-determination has been referred to elsewhere in South African law, most notably for present purposes in *Clark v Hurst No and Others*[176]. In

---

the angiogram and other invasive studies, and we will get paid five times as much". In the UK informed consent doctrine downplays patient choice in comparison with the US. Inter alia, say the authors, this is because in the UK medical care has long been viewed as a publicly provided good, and choices are constrained, by among other things, the total budget government commits to medical services. They point out that consumer advocates in Britain have not been silent in the wake of *Sidaway v Bethlehem Royal Hospital Governors* 1 All ER 643, 646 (1985) endorsing the *Bolam* test and are not persuaded that physicians alone should set the disclosure rules. Consumer complaints about continuing medical paternalism had some effect in the UK when the NHS took the reservation expressed by Lord Bridge in *Sidaway* concerning the Bolam test seriously and issued *Patient Consent to Examination or Treatment*, and a *Guide to Consent for Examination or Treatment* to all NHS doctors in September 1990. The NHS intended these documents to govern NHS practice and included the statement "where treatment carries substantial risks the patient must be advised of this by the doctor so that consent may be well-informed".

174 Palmisano D J 'Informed Consent' *Intrepid Resources* points out that informed consent is a legal doctrine in America that is defined in all 50 states as a consent to treatment obtained after adequate disclosure. He notes that what is considered to be 'adequate disclosure' varies from state to state. Informed consent is defined in most states as a consent obtained after telling the patient the following: the diagnosis; the nature of the proposed treatment; the name of the procedure; a description in layman's terms; risks associated with that treatment; alternatives and associated risks; and risk of no treatment. (http://www.intrepidresources.com/html/informed_consent.html)

175 Meisel A 'The 'Exceptions' to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking (1979) *Wis. L. Rev.* 413 at 460 n. 153 as cited by Côté A, 'Telling the Truth? Disclosure, Therapeutic Privilege and Intersexuality in Children' *Health Law Journal* Vol 8, 2000 p199

176 *Clarke* fn 55 *supra*

this case the court referred to the American case of *In the matter of Claire Conroy* [177] where it was stated that on balance the right to self-determination ordinarily outweighs any countervailing State interests (in preservation of the individual's life) and competent persons generally are permitted to refuse medical treatment even at the risk of death. Thirion J observed in *Clarke* that in South African law, the Court would not simply weigh the patient's interest in freedom from non-consensual invasion of his bodily integrity against the interest of the state in preserving life or the belief in the sanctity of human life; nor would it necessarily hold that the individual's right to self-determination and privacy always outweighs society's interest in the preservation of life. Furthermore, he said, in South African law a person who assists another to commit suicide may, depending on the circumstances of the particular case, be guilty of murder or culpable homicide[178].

In *C v Minister Of Correctional Services*[179] Kirk-Cohen J stated that consent is a defence to many acts which would otherwise be a delict. An obvious example is consent to surgery. In recent years the idea that consent must be 'informed consent' has found favour with our Courts (he referred to *Castell v de Greef* in this regard) He noted that in regard to surgery, 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'[180].

It is important to point out, with regard to the future of the doctrine of informed consent in South Africa that the National Health Act, which was passed by Parliament in 2003 makes detailed provision for informed consent in sections 6 and 7. The doctrine of informed consent has therefore become codified in South African law. Section 7 states subject to section 8 a health service may not be provided to a user without the user's informed consent unless –

177 *Conroy* 98 NJ 321; 486 A 2d 1209 (NJ 1985)

178 *Ex parte Minister van Justisie: In re S v Grotjohn* fn 59 *supra*

179 *C* 1996 (4) SA 292 (T)

180 As far as blood tests are concerned, Kirk-Cohen cited *Seetal v Pravitha and Another NO* 1983 (3) SA 827 (D) in which the headnote reads 828A-B: "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."

(a) the user is unable to give informed consent and such consent is given by a person:

(i) mandated by the user in writing to grant consent on his or her behalf; or

(ii) authorised to give such consent in terms of any law or court order;

(b) the user is unable to give informed consent and no person is mandated or authorised to give such consent, and the consent is given by the spouse or partner of the user or, in the absence of such spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the user, in the specific order as listed;

(c) the provision of a health service without informed consent is authorised in terms of any law or a court order;

(d) failure to treat the user, or group of people which includes the user, will result in a serious risk to public health; or

(e) any delay in the provision of the health service to the user might result in his or her death or irreversible damage to his or her health and the user has not expressly, impliedly or by conduct refused that service."

Section 7 (2) insists that: "A health care provider must take all reasonable steps to obtain the user's informed consent." While section 7(3) stipulates that: "For the purposes of this section "informed consent" means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6[181]."

Section 7 attempts to address some of the problems experienced by health care providers in obtaining consent for the treatment of persons who do not necessarily have the capacity to make the necessary decisions on their own but whose lack of capacity has not been officially recognised through some legal process. There are many elderly people who wander in and out of senility of various degrees and who often urgently require treatment in situations that fall far short of emergencies. Similarly there is a large number of children in South Africa who have been orphaned due to AIDS and whose legally recognised guardians are no longer available to give the necessary consent to treatment on their behalf. In fact in many cases there is no adult relative or family member available to give such consent. At present the

[181] See the discussion on informed consent to research below where section 6 is quoted in full.

provisions of section 39(2)[182] of the Child Care Act[183] allow for application to be made to the Minister of Health for authorisation of medical treatment but due to the large numbers of children involved and the fact that each individual case must be considered on its merits, this is not an ideal solution in the case of HIV and AIDS. Application can also be made to a court of law as the High Court in South Africa is the upper guardian of all minors but the process is once again cumbersome due to the fact that application must be made in respect of specifically identified children and each case must be considered on its merits. Section 39(1) of the Child Care Act stipulates that if any medical practitioner is of opinion that it is necessary to perform an operation upon a child or to submit him to any treatment which may not be applied without the consent of the parent or guardian of the child, and the parent or guardian refuses his consent to the operation or treatment, or cannot be found, or is by reason of mental illness unable to give that consent, or is deceased, that practitioner shall report the matter to the Minister, who may, if satisfied that the operation or treatment is necessary, consent thereto in lieu of the parent or guardian of the child.

It is submitted that the right of the user to be informed is significantly extended by the provisions of section 8 of the National Health Act which makes provision for situations in which people have already received treatment in situations in which for one reason or another their prior informed consent could not be obtained. Section 8(3) requires the same standard and level of disclosure as for informed consent as contemplated in section 6. Section 8 also makes provision for the participation of users in decisions affecting their health even where the informed consent itself must be given by another person. This is an attempt to recognise right to human dignity of children and the elderly who, although lacking capacity to a greater or lesser degree, may still be able to understand to some extent what is happening to them. Section 8 therefore imposes obligations upon providers over and above those normally contemplated by the common law doctrine of informed consent when it comes to situations in which it is not the patient him- or herself who is giving the consent.

---

182 According to this subsection: "If the medical superintendent of a hospital or the medical practitioner acting on his or her behalf is of opinion that an operation or medical treatment is necessary to preserve the life of a child or to save him or her from serious and lasting physical injury or disability and that the need for the operation or medical treatment is so urgent that it ought not to be deferred for the purpose of consulting the person who is legally competent to consent to the operation or medical treatment, that superintendent or the medical practitioner acting on his or her behalf may give the necessary consent."

183 Child Care Act No 74 of 1983

In an unreported case *Pop v Revelas* in the Witwatersrand Local Division of the High Court of South Africa handed down on 05 August 1999, the plaintiff claimed that he had provided no consent to the doctor for the procedure that was carried out. The doctor raised as proof of consent, the hospital consent document that had been signed by the patient. The doctor said that that document was quite clearly what appears to be a contract between the patient and the hospital. It was not a contract between the patient and the doctor. No evidence was led and it was not pleaded that the document was also a contract between the patient and the doctor.

The patient's evidence was that as far as he was concerned and understood, the document was a contract between him and the hospital. That did not affect the relationship between him and the doctor. The doctor's representatives argued that the document showed that there was consent to the specific operation that was carried out. The doctor wanted to draw the inference from the hospital consent that patient in fact consented to something more than the removal of a callosity, which was expressly consented to between the patient and the doctor. The difficulty for the doctor was that the inference was never put to witnesses. The court found that there was liability by the doctor to the patient on the basis that he carried out an operation which was not consented to. The case stood over for determination of the quantum of damages. The court determined that because there was no consent there was an unlawful invasion of the physical integrity of the patient, even if that was skilfully done[184].

The subject of informed consent in the context of medical research is a particularly vexed one. The fact that in South African law, informed consent is based upon the maxim *volenti non fit injuria* offers little protection to persons who consent to be human guinea pigs in clinical trials. In Canada, the 1980 Supreme Court decision in *Reibl v Hughes*[185] established the Canadian standard for informed consent to

---

184 The facts are as relayed by Dinnie D in 'Consent and Therapeutic Privilege' http://www.deneysreitz.co.za/news. He refers to another unreported judgment, *Jacobson v Carpenter-Kling*, a 1998 decision of the Transvaal Provincial Division of the High Court, in which an Ear Nose and Throat Specialist was sued by the patient for damages arising from lack of informed consent. It was alleged that there was a failure to provide information on the material risks inherent in the operation designed to relieve the patient's chronic sinusitis. Complications set in because of the leakage of cerebrospinal fluid. Further corrective surgery was required. Referring to the *Castell* decision, the court found that it was sufficient for a doctor to indicate the body parts on which the operation would be performed and to indicate "danger areas" that might be affected together with an indication that the required care would be exercised. The patient's claim failed on the facts. Dinnie states in the article that in his experience, except in cases where there has been lack of informed consent for HIV/AIDS blood testing resulting in an injuria, lack of informed consent as a ground of negligence in a malpractice claim has not successfully been pursued.

185 *Reibl* fn 150 *supra*

therapeutic treatment but the leading case in that country for consent in the context of research and experimentation in Canada is *Halushka v University of Saskatchewan et al*[186]. In this case Justice Hall argued that the duty owed by researchers toward prospective subjects is greater than that owed by medical practitioners to their patients. A stricter standard of disclosure in the research context is now generally accepted in law. Canadian legal commentators and researchers continue to cite *Halushka* as the leading case on informed consent to research[187]. It is submitted that the weakness of the Bolam test and the correctness of the approach to informed consent in South African law as evidenced by Ackermann J's decision in *Castell* as being based on the reasonable patient test is highlighted by discussions on informed consent to medical research. Why should the reasonable doctor test be applicable to situations of medical treatment and the reasonable person test be applicable to situations of medical research? The answer that the latter requires a higher standard of disclosure simply begs the question. If one unpacks the issues inherent in the difference between medical treatment and medical research they are not as obvious as

---

186 *Halushka* (1965), 53 D.L.R. (2d) 436 (Sask. C.A)

187 Pullman D 'Subject Comprehension, Standards of Information Disclosure and Potential Liability in Research' www.law.ualberta.ca/centres/hli/pdfs/hlr/v9/pullmanfrm.pdf. Pullman points out that this is understandable in that it is one of the few cases of this nature that has made its way through the courts. He notes that while it is also the case that established that the standard for consent to research is stricter than that applied to therapy, it can in fact be argued that Halushka invoked a weaker standard of informed consent than that which was subsequently applied in *Reibl v Hughes*. The facts of Halushka were that in 1961 the plaintiff, a student at the University of Saskatchewan volunteered to participate in a clinical trial to test a new drug. Although he signed a consent form that authorized the procedure, the physician researchers failed to inform him that the drug was a new anaesthetic about which they had little knowledge and with which they had no prior experience. They did not inform him that he might be exposed to certain unknown risks. Instead they assured him that there was nothing to worry about. Furthermore, while he was informed that the test would require that a catheter be inserted into a vein in his arm, it was not explained that this catheter would pushed up the vein and through his heart as the experiment proceeded. In fact when the catheter was advanced through the heart chambers and the anaesthetic administered, the plaintiff suffered a complete cardiac arrest. It took approximately one minute and thirty seconds to open his chest and separate his ribs so that manual heart massage could be performed. Although the researchers were able to resuscitate Halushka, he suffered some brain damage with a resulting diminution of mental ability. Justice Hall in ruling on this case acknowledged that ordinarily both medical therapy and medical research require prior informed consent from patients/subjects. He also noted that the difference between the therapeutic situation and the research situation may permit a different standard of informed consent in each context. This is because although therapeutic privilege applies in the treatment context, no such privilege applies in the research context. When the research is for scientific purposes only with no foreseeable therapeutic benefit for the patient or subject, there is clearly no 'therapeutic privilege' in view. Thus, Justice Hall argued that the research situation places a stricter duty and higher standard of disclosure on the physician researcher than that required in the therapeutic context. He stated that:
"In my opinion the duty imposed upon those engaged in medical research…to those who offer themselves as a subject for experimentation…is at least as, if not greater than, the duty owed by the ordinary physician or surgeon to his patient. There can be no exceptions to the ordinary requirement of disclosure in the case of research as there may well be in ordinary medical practice…The example of risks being properly hidden from a patient where it is important that he should not worry can have no application in the field of research. The subject of medical experimentation is entitled to a full and frank disclosure of all the facts probabilities and opinions which a reasonable man might be expected to consider before giving his consent." Pullman points out that in stating his position Justice Hall invokes the reasonable person standard of information disclosure. This standard requires that researchers disclose as much information as any reasonable person would expect to have in order to make an informed decision whether or not to participate in a clinical trial. He notes that the reasonable person standard is generally viewed as a compromise between the professional practice standard and the subjective person standard. The former requires researchers to disclose only as much information as other researchers working in the field would normally disclose [the equivalent of the British Bolam test for medical researchers]. Pullman points out that had the court relied upon the professional practice standard in Halushka, it would have called for expert witnesses from the research community to testify with regard to standard practice. By invoking the reasonable person standard, Justice Hall implicitly rejected the professional practice standard says Pullman. Furthermore, by requiring "full and frank disclosure" he set aside any appeal to therapeutic privilege as a justification for non-disclosure of information.

might first appear. Medical research and especially clinical trials are usually conducted with regard to a specific illness or health condition which means that those who volunteer for it must be aware of the exact nature of their diagnosis, using the reasonable person test, in order to be able to volunteer as a subject and to understand the associated risks to themselves. Whilst the goal of clinical trials is clearly not therapeutic and those participating in them should be referred to as subjects rather than as patients, those very same people, the subjects of the clinical trial, may be patients in the medical treatment context if the research is designed around a specific health condition. Thus an asthmatic may be a subject in a clinical trial of a new drug for asthma but that same person is likely to be a patient to the doctor who is treating him for his asthma. Why then should the reasonable person test be applicable in the clinical trial context and the reasonable provider test (the Bolam test) be applicable in the treatment context? The paternalism in the latter context is undeniable when one juxtaposes the clinical trial situation and the medical treatment situation. The argument might be raised that the risks associated with clinical trials are greater than those associated with medical treatment. It must be pointed out, however that in practice it is not as easy as it seems to draw a distinction between therapeutic interventions and purely research based interventions. There can be a strongly therapeutic aspect to a research intervention and, although some members of the general public may find it alarming, there is often also a research element in ordinary therapeutic interventions more particularly those involving the utilisation of medicines[188]. Systems for the reporting of adverse drug reactions are premised *inter*

---

188 Noah L in 'Informed Consent and the Elusive Dichotomy Between Standard and Experimental Therapy' *American Journal of Law and Medicine* Winter 2002 points out that: "To a greater or lesser extent all medical interventions have an experimental quality to them. Physicians try out things on their patients all the time. In many instances, we hope they do so based on well grounded confidence in the likely utility of a particular therapy, though even then the variability of patient response may disappoint our expectations. In far too many instances, unfortunately, physicians select interventions that remain poorly understood. Even for those therapeutic choices subject to federal licensing requirements, particularly pharmaceuticals, product approval does not define the point at which an investigational intervention passes the threshold into standard therapy. Instead the research phase continues after licensure, both in the sense that more safety data accumulates and insofar as physicians may improvise when using a product in ways not originally contemplated. Conversely and investigational product may become the standard of care even before federal regulators bestow their blessing on a particular use. To the extent that we encounter a spectrum rather than a bright-line distinction between standard and experimental interventions, it becomes especially important to understand just what might justify heightened informed consent requirements in the context of clinical trials and then decide whether to extend these to atypical experimental treatments. If for instance, greater uncertainty about risks and benefits, or fears of conflicts of interest, account for demanding and more thorough consent in the experimental context, then perhaps all encounters between physician-investigators and patient-subjects must account for these features of their relationship (in effect, informed consent on a sliding scale). Such an analysis casts serious doubts on the all or nothing approach of federal regulatory agencies and, conversely, it challenges the largely undifferentiated rules applied by the courts when they resolve medical malpractice litigation... For the most part, legal scholars who have addressed informed consent issues have paid scant attention to the special issues that arise in the research setting. In contrast, these issues have attracted a substantial commentary among those in the biomedical research community. This relative disinterest among legal scholars may reflect the fact that courts have not really given the topic separate consideration in the medical malpractice context, and that administrative agencies have done so only in one aspect of complex regulatory regimes for

alia on the fact that not every possible adverse reaction to a drug would have been discovered in the clinical trial phase. Pharmacovigilance programmes are intended to provide early warning signals of previously unknown adverse effects of medicines. The World Health Organization defines a signal as "reported information on a possible causal relationship between an adverse event and a drug, the relationship being unknown or incompletely documented previously"[189]. It has been observed[190] that before marketing a new drug many adverse drug reactions (ADRs) may either be suspected from chemical similarity to know drugs or detected in clinical trials. Detection if ADRs in clinical trials is hampered by the fact that rare ADRs and ADRs with a long time to onset are difficult to detect. Since trials are carried out under controlled circumstances, the detection of ADRs in specific populations, such as the elderly, women and children, patients with chronic diseases or patients with multiple drug use are even more difficult to detect. Spontaneous reporting systems are commonly used to detect new or unexpected ADRs after the marketing of drugs. Because of methodological reasons, such as selective under-reporting, spontaneous reporting systems can only be used to signal the possible existence of new or unexpected ADRs. Further pharmacoepidemiological studies are needed to evaluate these ADRs in more detail[191]. It has also been pointed out that clinical trials have become big business. Estimates suggest that as many as twenty million Americans have enrolled in formal biomedical studies. The reasons given for the proliferation of clinical trials in recent years are revealing. They include the fact that patients have become more interested in participating as research subjects either because their conditions have not responded to existing treatments or because they lack insurance coverage and resources to afford standard treatments[192]. It is submitted that the application of the maxim *volenti non fit injuria* in South African law in the context of both the doctrine of informed consent and the ordinary principles of the South African law of delict renders discussions as to the various tests for disclosure of information, and the problem of logical inconsistencies in test dichotomies in the various situations

---

the supervision of human subject research. Juxtaposing these two systems may offer some valuable insights because, as it happens, the rules that evolved in these separate domains have begun to converge."

189 *Canadian Adverse Drug Reaction Newsletter* Vol 8 No 3 July 1998. It is stated in the newsletter that spontaneous reporting systems play a major role in the detection of new adverse drug reactions. In fact, in most instances it is the only early signalling method available for newly marketed drugs and infrequently used drugs. http://www.hc-sc.gc.ca

190 Van der Heijden PGM, van Puijenbroek EP, van Buuren S and van der Hofstede JW 'On the Assessment of Adverse Drug Reactions From Spontaneous Reporting Systems: The Influence of Under-Reporting on Odds Ratios' *Statistics in Medicine* 2002 21: 2027-2044

191 Van der Heijden PGM, van Puijenbroek EP, van Buuren S and van der Hofstede JW fn 190 *supra*

192 Noah L fn 188 *supra*

encountered on the spectrum of health services delivery, largely academic. The standard of care in the law of delict is that of the reasonable person. A person is negligent in terms of the South African law of delict if his actions or omissions do not measure up against those of a reasonable person in his situation. Failure to disclose a risk which is likely, in the judgment of a reasonable person, to materially affect a decision of another reasonable person in consenting to a situation which includes that risk is not, in itself, reasonable. It impairs consent and consent is a factor that vitiates wrongfulness. Since in South Africa, medical interventions are *prima facie* unlawful, a person who ensures that he or she obtains informed consent to the extent necessary to achieve the desired exculpatory effect is therefore unlikely to attract delictual liability should the risk materialise. The risk would have successfully been transferred to the patient/subject. Although the court in *Castell* framed the test as the reasonable patient test, and it is respectfully submitted, correctly so[193], one can for the purposes of the law of delict consider this test from the perspective of the provider as well since the test requires that the provider puts him or herself in the position of the reasonable patient in determining the nature and level of disclosure that is required in a particular situation. In other words the provider must ask herself what it is that a reasonable patient in the situation of the patient before her would want to know. In doing so, the provider must herself act reasonably. If a court then subsequently has to consider a claim in delict, it will in applying the same test, be likely to come to the same conclusion as did the provider when informing her patient, concerning the nature and extent of the disclosure that was required in the particular circumstances.

In the United States of America there is a Federal Policy for the Protection of Human Subjects which deals with the subject of informed consent for research purposes.[194]

---

193 It is submitted that the reasonable patient test is logically the only one that can be applied in a system which operates from the point of view that medical interventions are prima facie unlawful. To apply the Bolam test would be to allow the medical profession to be a judge in its own case.

194 The disclosure requirements found in the Federal Policy for the Protection of Human Subjects at 45 CFR 46.116(a), under the heading of "basic elements of informed consent," are as follows:
1. a statement that the study involves research, an explanation of the purposes of the research and the expected duration of the subject's participation, a description of the procedures to be followed, and identification of any procedures which are experimental;
2. a description of any reasonably foreseeable risks or discomforts to the subject;
3. a description of any benefits to the subject or to others which may reasonably be expected from the research;
4. a disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject;
5. a statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained;
6. for research involving more than minimal risk (as defined in 45 CFR 46.102(i)), an explanation as to whether any compensation and an explanation as to whether any medical treatments are available if injury occurs and, if so, what they consist of, or where further information may be obtained;

There are no South African cases on the subject of informed consent to research. However the National Health Act provides in section 71 that:

(1) Notwithstanding anything to the contrary in any other law, research or experimentation on a living person may only be conducted-

(a) in the prescribed manner; and

(b) with the written consent of the person after he or she has been informed of the objects of the research or experimentation and any possible positive or negative consequences on his or her health.

(2) Where research or experimentation is to be conducted on a minor for a therapeutic purpose, the research or experimentation may only be conducted-

(a) if it is in the best interests of the minor;

(b) in such manner and on such conditions as may be prescribed;

(c) with the consent of the parent or guardian of the child; and

(d) if the minor is capable of understanding, with the consent of the minor.

(3) (a) Where research or experimentation is to be conducted on a minor for a non-therapeutic purpose, the research or experimentation may only be conducted-

(i) in such manner and on such conditions as may be prescribed;

(ii) with the consent of the Minister;

(iii) with the consent of the parent or guardian of the minor; and

(iv) if the minor is capable of understanding, the consent of the minor.

(a) The Minister may not give consent in circumstances where –

(h) the objects of the research or experimentation can also be achieved if it is conducted on an adult;

(ii) the research or experimentation is not likely to significantly improve scientific

(iii) understanding of the minor's condition, disease or disorder to such an extent that it will result in significant benefit to the minor or other minors;

---

7. an explanation of whom to contact for answers to pertinent questions about the research and research subjects' rights, and whom to contact in the event of a research-related injury to the subject; and
8. a statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at anytime without penalty or loss of benefits to which the subject is otherwise entitled (45 CFR 46.116(a)).

It should be noted that these requirements could be modified or waived by an Institutional Review Board (IRB) under certain circumstances. In addition to the basic information listed above, the U.S. regulations require that participants be given other information that may affect their participation in research, depending on the nature of the project itself. The U.S. regulations list six such additional disclosures (45 CFR 46.116(b)). (Source: *Ethical and Policy Issues in International Research: Clinical Trials in Developing Countries* Chapter 3 'Voluntary Informed Consent' www.georgetown.edu/research/nrcbl/nbac/clinical/Chpa3.html

(iv) the reasons for the consent to the research or experimentation by the parent or guardian and, if applicable, the minor are contrary to public policy;

(v) the research or experimentation poses a significant risk to the health of the minor; or

(vi) there is some risk to the health or wellbeing of the minor and the potential benefit of the research or experimentation does not significantly outweigh that risk.

9.2.12 *Friedman v Glicksman*[195]

Facts

The plaintiff alleged that:

1. When pregnant, she consulted the defendant, a specialist gynaecologist, to advise her apropos of the risk that she might have been pregnant with a potentially abnormal and/or disabled infant.
2. It was understood between the plaintiff and the defendant that the plaintiff wished to terminate her pregnancy if there was any risk greater than the normal risks of the infant being born in an abnormal and/or disabled condition.
3. An agreement was concluded in terms of which the defendant would provide such advice in order that the plaintiff might make an informed decision on her own behalf and on behalf of Alexandra whether to terminate the pregnancy or not.
4. In the alternative the defendant, by virtue of his professional status, was under a duty to provide the advice to the plaintiff both in her personal capacity and on behalf of Alexandra for the purpose set out in 3 above. In this regard he had to act with the skill, knowledge and diligence normally exercised by other members of his profession.
5. The defendant, having carried out certain tests, advised the plaintiff that there was no greater risk than the normal risk of
   having an abnormal and/or disabled child and that it was quite safe for her to proceed to full term to give birth.
6. The defendant's advice was erroneous and Alexandra was born disabled on 5 March 1991.

---

195 *Friedman* 1996 (1) SA 1134 (W)

7. The defendant in giving his advice had acted negligently in a number of respects. Had he not acted in this negligent manner he would have concluded that there was a greater than normal risk of the child being born disabled and would have advised the plaintiff of this fact.
8. Had she received the correct advice the plaintiff would have terminated her pregnancy forthwith.
9. The defendant's negligence was a breach of his duty of care as well as a breach of the agreement concluded.

Based on these facts plaintiff has brought two claims - a claim in her personal capacity for the expenses of maintaining and rearing Alexandra as well as all future medical and hospital treatment and other special expenses and claim in her representative capacity on behalf of Alexandra for general damages as well as a claim for future loss of earnings.

Judgment

Goldblatt J noted that claims of this nature have been the subject of many reported judgments in foreign countries and have been the subject of many academic articles both in South Africa and abroad. He examined the terminology used for the various claims that fell into the same category and identified some common terms which he said do contain certain emotional and apparent value judgments which can detract from a proper judicial approach to the issues raised. These are as follows:

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

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

'Wrongful life' actions are those brought by the child on the basis that the doctor's negligence - his failure to adequately inform the parents of the risk - has caused the

birth of the disabled child. The child argues that, but for the inadequate advice, it would not have been born to experience the pain and suffering attributable to the disability.

Goldblatt J stated that different considerations applied to the claims instituted by the plaintiff in that the one claim was a 'wrongful birth' claim and the other a 'wrongful life' claim. He noted that the defendant argued that it would be against public policy to enforce the contract entered into between the plaintiff and the defendant because it would encourage abortion and thus be inimical to the right to life enshrined in section 9 of the Constitution of the Republic of South Africa Act[196] as well as to the generally recognised sanctity accorded by society to life and the process by which it is brought about but said that there was no substance in this submission, which flew directly in the face of the Abortion and Sterilisation Act 2 of 1975. In terms of section 3(c) of that Act an abortion may be procured: 'where there exists a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that he will be irreparably seriously handicapped'.

Thus, said Goldblatt J, the Legislature had recognised, as do most reasonable people, that cases exist where it is in the interests of the parents, family and possibly society that it is better not to allow a foetus to develop into a seriously defective person causing serious financial and emotional problems to those who are responsible for such person's maintenance and well being. He stressed that the election to proceed with or terminate the pregnancy in these circumstances rests solely with the mother, who, he said, bears the moral and emotional burden of making such election. It was the view of the court that the contract entered into between the plaintiff and the defendant was sensible, moral and in accordance with modern medical practice. It said that the plaintiff was seeking to enforce a right, which she had, to terminate her pregnancy if there was a serious risk that her child might be seriously disabled. And noted that decision of the Appellate Division in *Administrator, Natal v Edouard*[197], in upholding a 'wrongful pregnancy' claim, in which the Appellate Division found such claim not to be contrary to public policy. Consequently said Goldblatt J, a 'wrongful

196 Act No 200 of 1993
197 *Edouard* 1990 (3) SA 581 (A)

birth' claim is not contra bonos mores. He did say, however, that different considerations may apply to a 'wrongful life' claim.

The court observed that in the present case the defendant was employed to prevent - by way of giving proper medical advice - the birth of a disabled child and that because of his negligence that event had taken place, causing the plaintiff to incur considerable expenses which she would not otherwise have had to incur. Quoting from van Heerden JA in *Edouard* it stated that -

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

and pointed out that in America a claim for 'wrongful birth' is commonly recognised[198]. The court agreed with the reasoning of the American court in *Berman v Allan*[199] saying that the reasoning of the American Courts is sound and fits comfortably within the Aquilian action. Goldblatt J observed that a doctor acts wrongly if he either fails to inform his patient or incorrectly informs his patient of such information she should reasonably have in order to make an informed choice of whether or not to proceed with her pregnancy or to legally terminate such pregnancy. He pointed out that the fault element of the delict is to be found in the foreseeability of harm which the doctor-patient relationship gives to the doctor and stated that once proper disclosure is not made and the patient is deprived of her option, the damages she suffers by giving birth to a disabled child are clearly caused by the fault of the doctor, provided she would have terminated the pregnancy if the information had been made available to her. Goldblatt J said that he was accordingly satisfied that in regard to her claims in her personal capacity, the plaintiff's particulars of claim contained

---

198 According to Goldblatt J, this claim was first recognised by the Supreme Court of New Jersey in *Berman v Allan* 404 A 2d 8 (1979). He quoted from Pashman J who in that case said the following: "The Supreme Court's ruling in *Roe v Wade* clearly establishes that a woman possesses a constitutional right to decide whether her foetus should be aborted, at least during the first trimester of pregnancy. Public policy now supports, rather than militates against the proposition that she not be impermissibly denied a meaningful opportunity to make that decision. As in all other cases of tortious injury, a physician whose negligence has deprived a mother of this opportunity should be required to make amends for the damage he has proximately caused. Any other ruling would in effect immunize from liability those in the medical field providing inadequate guidance to persons who would choose to exercise their constitutional right to abort foetuses which, if born, would suffer from genetic defects. (Notes omitted.) Accordingly, we hold that a cause of action founded upon a wrongful birth is a legally cognizable claim.'

199 *Berman* fn 198 *supra*

averments sufficient to sustain an action and that this cause of action was a logical extension of the principle enunciated by the Appellate Division in *Edouard*.

With regard to the claim in respect of the child, Alexandra, Goldblatt J noted that the defendant excepted to this claim on the following independent grounds:

1. In so far as the plaintiff's claim was based on a breach of contract, Alexandra was not a party to such contract and cannot be affected by any such breach.
2. The defendant did not owe Alexandra a duty of care which would lead to the termination of her existence.
3. The defendant did not in law act wrongfully against Alexandra.
4. There was no legal basis in South African law for the damages claimed on behalf of Alexandra. A Court is not able to evaluate damages by comparing the value of non-existence and the value of existence in a disabled state.
5. The action was *contra bonos mores* and against public policy.

Goldblatt J agreed that the plaintiff could neither enter into a contract on behalf of Alexandra prior to Alexandra's birth or at such time make any election on Alexandra's behalf. He said it is trite law that an agent cannot act on behalf of a non-existent principal and it is similarly trite that legal personality only commences at birth. In these circumstances, he said, the allegation that the plaintiff acted on Alexandra's behalf whilst she was still *in utero* was legally untenable. He stated that it could also not be argued that this was a contract for the benefit of a third party as such party could only accept the benefit as such at a time when the alleged benefit, i.e. termination of pregnancy, was no longer possible.

According to the court it was thus necessary to consider whether Alexandra had a delictual claim against the defendant for allowing her to be born with her disabilities instead of giving the plaintiff such advice as would have caused her to terminate her pregnancy and cause Alexandra never to have existed in the legal sense. It said that the first question to be answered in relation to the delictual claim was whether a person has an action in respect of injury inflicted on him while he was still a foetus in his mother's womb and referred to *Pinchin and Another NO v Santam Insurance Co*

Ltd[200] in which it was answered in the affirmative. Goldblatt J noted that Hiemstra J in coming this decision, which in the end was *obiter*, carefully considered all the authorities and arguments for and against the proposition and that his obiter decision was greeted with approbation by all the academic writers who dealt with it. He said that he did not intend repeating Hiemstra J's arguments, all of which he found persuasive and with which he agreed.

He was of the opinion that in the present case it was not necessary to invoke the nasciturus rule because Alexandra's action did not arise when the pregnancy was not terminated, but when she was born[201]. The plaintiff argued that, once the mother is entitled to sue, on the basis that fault and causation are proved, there is no reason in law or logic why a child should not equally be able to sue for its damages, including general damages for pain and suffering, disability, loss of amenities and loss of earnings since these consequence flow directly and foreseeably from the initial delict. The plaintiff also submitted that the proper measure of damages was the amount necessary to compensate the child for having to live in a disabled state and not the difference between non-existence and existence in a disabled state. Goldblatt J noted that the action for 'wrongful life' has been considered in a number of American cases and has in the main failed[202]. He said in his view that the reasoning of the American

---

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

201 The court referred to W A Joubert (1963) 26 *THRHR* 295 and Boberg 'An Action for Wrongful Life' (1964) 81 *SALJ* at 501.

202 Goldblatt J provided the following useful survey of the legal position on the subject in other countries-
"The view of the majority of the American Courts was expounded by Cercone J in *Speck v Finegold* Pa 268 Super 342 (1979); 408 A 2d 496 where he said the following at 508 [7]:
'In the instant case, we deny Francine's claim to be made whole. When we examine Francine's claim, we find regardless of whether her claim is based on "wrongful life" or otherwise, there is a failure to state a legally cognizable cause of action even though, admittedly, the defendants' actions of negligence were the proximate cause of her defective birth. Her claims to be whole have two fatal weaknesses. First, in appellate judicial pronouncements that hold a child has no fundamental right to be born as a whole, functional human being. Whether it is better to have never been born at all rather than to have been born with serious mental defects is a mystery more properly left to the philosophers and theologians, a mystery which would lead us into the realm of metaphysics, beyond the realm of our understanding or ability to solve. The law cannot assert a knowledge which can resolve this inscrutable and enigmatic issue. Second, it is not a matter of taking into consideration the various and convoluted degrees of the imperfection of life. It is rather the improbability of placing the child in a position she would have occupied if the defendants had not been negligent when to do so would make her non-existent. The remedy afforded an injured party in negligence is intended to place the injured party in the position he would have occupied but for the negligence of the defendant. Thus, a cause of action brought on behalf of an infant seeking recovery for a "wrongful life" on grounds she should not have been born demands calculation of damages dependent on a comparison between Hobson's choice of life in an impaired state and non-existence. This the law is incapable of doing.'
In the same case Spaeth J at 512 stated his objection to the cause of action in these words: 'If it were possible to approach a being before its conception and ask it whether it would prefer to live in an impaired state, or not to live at all, none of us can imagine what the answer would be. We can only speculate or refer to various religious or philosophical beliefs. We cannot give an answer susceptible to reasoned or objective valuation.'
In *Philips v United States* 508 F Supp 537 (1980) the District Court of South Carolina dismissed a 'wrongful life' claim after considering all the then reported American cases on the basis of the fundamental policy of the preciousness and sanctity of human life. They accepted it as basic to the beliefs of society that life, with or without a major physical handicap, is more precious than non-life.

Courts in holding that no cause of action exists in regard to a 'wrongful life' claim and the very cogent reasoning of the English Court of Appeal along the same lines were correct and agreed both with the conclusions reached and the reasons therefor. He held that South African law similarly cannot recognise that the facts alleged by the plaintiff on behalf of Alexandra are sufficient to sustain a cause of action and that it would be contrary to public policy for Courts to have to hold that it would be better for a party not to have the unquantifiable blessing of life rather than to have such life albeit in a marred way. He also said that to allow such a cause of action would open the door to a disabled child being entitled to sue its parents because they may have for a variety of reasons allowed such child to be born knowing of the risks inherent in such decision. Goldblatt J took the view that to allow damages to be claimed on the basis alleged by the plaintiff is completely contrary to the measure of damage allowed for in the law of delict. The defendant was in no way responsible for the child's disabilities and yet he was being asked to compensate the child for such disabilities. This proposition, he said, is illogical and contrary to the South African legal system. The only measure of damages can be the difference in value between non-existence and existence in a disabled state. He found that no criteria, in law, can exist in establishing such difference or even in establishing whether any damage has been sustained. Accordingly, the exception to plaintiff's claims in her personal capacity was dismissed and the exception to plaintiff's claims in her capacity as mother and natural guardian of her minor child, Alexandra, was upheld and such claims were dismissed.

Discussion

In California in *Curlender v Bio-Science Laboratories* App 165 Cal Rptr 477, the Court of Appeal allowed a wrongful life claim for damages on the basis that there should be a remedy for every wrong committed. This approach is in my view illogical and contrary to legal principles in that it ignores the central question of whether a wrong had in fact been committed. In England the question of whether or not a claim for 'wrongful life' existed was dealt with by the Court of Appeal in *McKay and Another v Essex Area Health Authority and Another* [1982] 2 All ER 771 (CA). The Court found that no cause of action existed for a number of reasons. Firstly, the Court held that the defendant was under no duty to the child to give the child's mother an opportunity to terminate the child's life. Whilst such a duty may be owed to the mother it could not be owed to the child. To impose such a duty towards the child would, in my opinion, make a further inroad on the sanctity of human life which would be contrary to public policy. It would mean regarding the life of a handicapped child as not only less valuable than the life of a normal child, but so much less valuable that it was not worth preserving. . . .' (Per Stephenson LJ at 781e.) The Court further held, as had many American Courts, that it was impossible to calculate damages being the difference between an impaired life and no life. 'But how can a court begin to evaluate non-existence, "The undiscover'd country from whose bourn No traveller returns"? No comparison is possible and therefore no damage can be established which a court could recognise. This goes to the root of the whole cause of action.'(Per Ackner LJ at 787h.)

Neethling *et al*[203] note that parents also have a claim for maintenance and medical expenses resulting from the wrongful birth of a disabled child. This claim is based on eg a medical doctor's omission to inform parents that their unborn child may be disabled thereby depriving them of the opportunity of deciding to have the child or not. They point out that the disabled child, however, does not have an analgous action for loss of future earnings based on so-called wrongful life.[204] Decisions in this category have proven to be fairly controversial in other jurisdictions with no real consensus. It has been noted that pre-natal torts and birth-related causes of action have become more accepted by courts and legislatures but that there is still controversy as to the kinds of damages that are recoverable[205]. Although a complete international comparison of the law of other jurisdictions is beyond the scope of this thesis it would be illustrative to look at the position in the United Kingdom and Australia which both use common law systems that are similar to that of South Africa. The American cases other than those to which the South African courts have already made reference differ too widely on this subject to be of much assistance.

In the UK, prior to *MacFarlane v Tayside Health Board*[206] the law for recovery of damages in wrongful conception cases was as set down by the Court of Appeal in *Emeh v Kensington and Chelsea and Westminster Area Health Authority*[207] and *Thake v Maurice*[208]. In *Emeh* a disabled child was born to a healthy mother following a failed sterilisation operation. The Court of Appeal allowed recovery of damages for pain, suffering and loss of amenity and special damages consequent on pregnancy and

---

203 Neethling *et al* fn 53 *supra* at p 281

204 See also Strauss 'Wrongful Conception', 'wrongful birth' and 'wrongful life': the first South African cases' 1996 Medical Law 15(1) p161-173; Blackbeard M 'Actions for Wongful Birth and Wrongful Life' 1996 *THRHR* 711-715 and Pearson F 'Liability for so-called Wrongful Pregnancy, Wrongful Birth and Wrongful Life' 1997 *SALJ* 91 *et seq*

205 Alvarez I J 'A Critique of the Motivational Analysis In Wrongful Conception Cases'. The author states that on wrongful conception cases, courts attempt to balance plaintiffs' injuries with public policy concerns involving the valuation of infant's lives. In balancing these interests the courts have used different rules and sometimes have deviated from traditional tort law principles. http://infoeagle.bc.edu/bc_org/avp/law/lawsch/journals/bclawr/41_303/03_TXT.htm
Thomas CM 'Claims for Wrongful Pregnancy and Child Rearing Expenses' observes that "Wrongful birth claims relate to the birth of a child as a consequence of medical negligence. There has been general acceptance by courts in various jurisdictions that costs relating to the pregnancy and birth may be recovered. However the more contentious issue is whether there is liability for the costs of rearing such a child. The English courts have held there is no such liability with respect to a healthy child, while in Australia, the Queensland Court of Appeal has taken the opposite view. In New Zealand the issue has yet to be decided. The Accident Compensation scheme has limited the development of the law relating to personal injury in general, but the High Court has found that the scheme does not prevent claims for wrongful birth. It is argued that the New Zealand courts should follow the Australian decisions, as the English approach is based on the views of ordinary people on this moral question as perceived by judges. This requires the individual judge's sense of the moral answer to a question to prevail, albeit in light of the judge's view of the opinions of ordinary people. It is argued that this is a subjective approach in that, in such a complex and emotionally difficult area of the law, there is unlikely to be uniformity of opinion among the public, or even among judges. As such, this is arguably a matter better resolved by legislation than by the courts." http://www-accountancy.massey.ac.nz (30 September 2002)

206 *MacFarlane* [2002] 2 AC 59, HL (Sc)

207 *Emeh* [1985] 1 QB 1012

208 *Thake* [1986] 1 QB 644

birth. It also allowed recovery of the costs of maintaining the child to adulthood. This decision was followed in *Thake* (*supra*). In the case of *MacFarlane* (supra) the parents decided that their family was complete and therefore MacFarlane had a vasectomy. Following the operation his sperm count was measured and he was told by the surgeon that it was negative. A few months later Mrs MacFarlane became pregnant. All five of the law Lords took the view that the claim for maintenance and upbringing of their child was a claim for pure economic loss. With the exception of Lord Millet they all held that damages for pain, suffering and loss of amenity caused by the pregnancy and birth of the child were recoverable. Special damages consequent on the pregnancy and birth of the child were also recoverable. However the costs of maintenance and education of the child were not. It has been observed that the opinions of their Lordships in MacFarlane illustrate the differing approaches to identifying situations in cases of economic loss outside the normal run of cases involving physical injury or damage[209]. In Australia on 16 July 2003 the High Court in

---

209 Author not stated: '"Wrongful conception"- economic loss, damages and ethical dilemmas'. The author notes that "In Brooke LJ's judgment in Parkinson [*Parkinson v St James and Seacroft University Hospital NHS Trust* [2001] All ER (d) 125 (Apr)] (pp 381B–385B) provides an interesting commentary on the development of claims for economic loss in the tort of negligence since *Anns v Merton London Borough* [1978] AC 728.
He identified five approaches to the question in the judgments of the House of Lords in *MacFarlane*: whether there had been an assumption of responsibility; what the purpose of the operation was; whether there were analogous established categories of negligence; what the result of the three stage test in *Caparo Industries v Dickman* [1990] 2 AC 605 was; and whether considerations of distributive justice provided a more just solution than considerations of corrective justice. Brooke LJ applied each of these approaches separately in Parkinson.
One of the above approaches of the Lords in *MacFarlane* is worth commenting on as it seems to have become particularly fashionable in the higher echelons of the judiciary. 'Distributive justice' requires reference to the way in which burdens and losses are distributed throughout society. The reasonable man is invoked to consider fairness between one class of claimants and another. In contrast, 'corrective justice' requires someone who has harmed another without justification to indemnify the other for the consequences of that harm. The concept of distributive justice was applied by Lord Hoffman in *White* v *Chief Constable of the South Yorkshire Police* [1999] 2 AC 455. He held in that case that the ordinary man would consider it unfair for the police officers in *White* to recover damages for psychiatric injury following the Hillsborough disaster when relatives had not been allowed to recover for the same injury in *Alcock* v *Chief Constable of the South Yorkshire Police* [1992] 1 AC 310. Lord Steyn applied the concept of distributive justice and concluded that if the hypothetical commuter on the Underground were asked the question whether the parents of an unwanted but healthy child should be able to sue the doctor for compensation equivalent to the cost of bringing up the child to adulthood the overwhelming number of commuters would say no on the basis of a premise as to what is morally acceptable and what is not (p 82B). It was emphasised in the opinions of Lords Slynn and Clyde that *MacFarlane* was concerned with a healthy child: the conclusions might be different if the child were to be born disabled. Cases since *MacFarlane* have focused on the following issues:

- Whether the parent(s) of a disabled child are able to recover damages for the costs of maintaining him or her and whether or not the parent(s) are able to recover the additional costs associated with having a disability (*Parkinson* v *St James and Seacroft University Hospital NHS Trust* [2001] ECWA Civ 530; [2001] 3 All ER 97).
- Whether a disabled parent is able to claim the additional costs associated with the disabled parent's disability in bringing up a healthy child (*Rees* v *Darlington Memorial Hospital* [2002] WLR 1483).
- Whether a brain-damaged parent of a healthy child is able to recover the grandparents' costs of maintaining the child until majority (*AD* v *East Kent Community NHS Trust* [2003] 3 All ER 1167).

The author summarises the position in the UK as follows:

- "In the case of a healthy mother and child damages for wrongful conception are only recoverable for pain, suffering and loss of amenity caused by the pregnancy and birth as well special damages consequent thereon. The costs of educating, upbringing and maintaining the child to adulthood are not recoverable (*MacFarlane*).
- Where the child is born disabled the additional costs of maintenance due to the disability are recoverable but not the ordinary costs of bringing up the child (*Parkinson*).
- Where the mother is disabled the additional costs of maintaining the healthy child which are due to the disability are recoverable but not the ordinary costs of bringing up the child (this decision is shortly to be looked at by the House of Lords) (*Rees*).

Cattanach v Melchior[210] upheld an award of more than $105 000 compensation for the costs of maintenance to the parents of a child born as a result of negligent gynaecological advice. This was the first time the High Court had made a ruling on the issue. Mr and Mrs Melchior are the parents of a son born in 1997 despite the performance of a sterilisation procedure by Dr Cattanach in 1992. Prior to the sterilisation procedure, Dr Cattanach had accepted at face value the mother's history that her right ovary and fallopian tube had been removed at the age of 15 following an appendectomy. He applied a Filshie clip to the plaintiff's left fallopian tube only. Mrs Melchior subsequently conceived by transmigration of an ovum from her left ovary to her right fallopian tube. The Supreme Court of Queensland held that the doctor was negligent in failing to advise the plaintiff that the absence of her right fallopian tube had not been clinically confirmed, that there was a procedure which would confirm the patency of the right fallopian tube and that in the absence of the performance of this procedure, the plaintiff faced a considerably increased risk of pregnancy following sterilisation. The court awarded damages for pain and suffering involved in the unexpected pregnancy together with the cost of past and future medical care and assistance involved in bringing up her son. The father was awarded a nominal amount in damage for the loss of consortium and both parents were awarded just over $105 000 for the past and future costs of raising their son. In June 2001 the majority of the Queensland Court of Appeal upheld the trial judge's findings on liability and the awards of compensation to the parents. Special leave was granted to appeal to the High Court solely in relation to the issue of whether the parents were entitled to claim the costs of raising their child. The appellant's main ground of contention was that the Court of Appeal had erred in not applying the decision of the House of Lords in *MacFarlane* (supra).

Interestingly, the Attorneys General of South Australia and Western Australia intervenined in the appeal in *Cattanach* and made submissions on the increased financial burden that would fall on the public health system if the appeal was not

---

- Where the mother is disabled and the grandparents bring up the healthy child the costs of maintenance are not recoverable (this decision is also being appealed) (*AD*).
- In considering whether or not damages are recoverable in case of pure economic loss, the courts have begun to use a range of approaches. In addition to the three-stage *Caparo* test and whether or not there has been an assumption of responsibility they have begun to consider distributive justice (ie whether or not a decision is fair between one class of claimants and another) and other approaches (see judgment of Brooke LJ in *Parkinson*).

http://www.butterworths.co.uk/pionline/journal/archive/2003/wrongful_conception.htm

210 *Cattanach* [2003] HCA 38

upheld. In a 4:3 majority, the High Court dismissed the appeal and upheld the decision of the Court of Appeal. The judges held that as a matter of law, the question of whether the respondents should be allowed to recover compensation for the cost of raising their child was a straightforward one to answer – the accepted common law principles for recovery of damages for negligent advice clearly entitled the respondents to claim for the costs of child maintenance as reasonably foreseeable consequences of the appellant's breach of duty. They made it clear that the appellant's submissions did not explain why the law should shield him from what were otherwise recoverable damages. The majority stated that *MacFarlane* is not persuasive authority in Australia and noted that the House of Lords expressly rejected the notion of public policy as a ground upon which to deny the recovery of the costs of child maintenance and that they saw no compelling reason why public policy should be invoked in the appeal, a fact which the dissenting judges also acknowledged. Hayne J doubted whether there was any accepted public policy against recovery which the community as whole recognisd and believed in. The court rejected the secondary argument that damages awarded should be offset by the benefits of having the child as being inconsistent with Australian law and unjustifiable as a matter of legal principle. The majority also criticised the unconvincing argument that the birth of a child should be regarded as a benefit and a blessing, an argument that ignored the fact that millions of people use contraception daily to avoid this result. They also said that it was highly speculative to bar recovery on the basis that a child who was the subject of litigation could be harmed by this knowledge in later life[211].

It is submitted that the decision of the Australian court is thus consistent with the decisions of the South African courts in *Friedman* and in *Edouard*[212]. The Australian decision also has the effect of demystifying, along with the South African judgments, such cases as being anything more than ordinary claims for pure economic loss and for non-patromonial 'loss', such as pain and suffering and loss of amenities, that are usually recognised in terms of the law of delict. The court saw public policy issues as being used if anything to preclude the claim for maintenance rather than to support it. This indicates that the normal and usual position in Australian law would be that

---

211 Nicolle M and Hopley, P 'Damages Awarded in 'Wrongful Birth' Case for the Costs of Child Maintenance' *Health Law Alert* 25 July 2003 Ebsworth & Ebsworth www.ebsworth.com.au

212 *Edouard* fn 197 *supra*

maintenance would be payable in the circumstances of *Cattanach*. Raising a child is an expensive business. A child that did not form a part of its parents' future plans may have a limited and not too bright future of its own if its parents can ill afford to raise it. Furthermore, the need to support and maintain another child may adversely prejudice the interests and opportunities of older siblings that were planned and conceived in accordance with their parents' financial and other resources. Even taking into account public policy considerations, it is submitted that there are at least as many policy reasons that support an award in damages for the maintenance and upbringing of a child as there are those that do not and, it is submitted, the former may be a great deal more rational and practical than the latter in many instances. It is submitted with respect that the decisions of both the South African courts and the Australian courts demonstrate an eminently sensible and pragmatic approach to the problem of wrongful conception. It takes into account the imbalance of power between the provider and the patient who has no possible way of knowing whether or not he or she has been sterilised or that the child *in utero* is disabled, except to conceive a child or give birth to that child respectively – a result that in either case is the very situation that is sought to be avoided. In both instances the patient is utterly dependent upon the expertise and professionala advice of the provider. It is submitted that in the case of South Africa, the judgments are also in keeping with the Constitution which grants a right of access to reproductive care in section 27(1). As stated previously, access does not mean access to medical negligence and substandard medical advice or treatment. Furthermore, section 28 of the Constitution clearly sets out the rights of children as being inclusive of basic nutrition, shelter, basic health care services and social services and that a child's best interests are of paramount importance in matters concerning the child. It is submitted that in order for the rights of the child to be adequately recognised and the constitutional principle of the paramountcy of the child's best interests to be observed it is difficult to see how a court could not decide in the manner in which it did in *Friedman*. There are likely to be very few cases indeed where the child would not benefit from an award to its parents in respect of its maintenance and upbringing especially in the uncertainties that plague modern life such as unemployment and violent crime. If one accepts the idea in principle that a child can be born in consequence of the delict of a provider of health services then it is submitted that whether the child is healthy or disabled becomes simply a question of the quantum of damages payable to the parents since, if

the provider had done his or her job properly, the child would not have been born, disabled or not. If the child is disabled as the result of negligent medical treatment then it may have a claim for damages in South Africa law on the basis of the *nasciturus* rule. This would not be a claim for wrongful birth so much as a claim for an injury to the child while it was still a foetus in its mother's womb.

9.2.13 Gibson v Berkowitz[213]

Facts

The facts as they appear from the judgment of Claasen J are as follows. On 19 June 1992 the plaintiff complained to her general practitioner, Dr Reyneke, of lower abdominal pain and she presented with a vaginal discharge and a burning sensation. Dr Reyneke referred her to the first defendant. She consulted him during July 1992 on a number of occasions. Several tests were done which eventually led to the first defendant advising her that precancerous cells existed in her vagina and that they had to be cauterised by way of a Lletz procedure. On 8 September 1992 she was admitted to the second defendant's hospital and under general anaesthetic the pre-cancerous cells were negligently swabbed with 100% instead of 3% glacial acetic acid, causing burns to the plaintiff's vulva, perineum, peroneal region and vagina. The acid was washed down from her vagina with water, ran down her natal cleft and soaked into the towelling under the small of her back, causing extensive full thickness third degree burns to her sacrum and buttocks, in size approximately 200 mm long in the transverse plain and 100 mm in the vertical dimension. When the plaintiff came to in the ward she screamed with pain, claiming that she was on fire. Her mother Mrs Zackie looked at the injuries on her back. According to her they looked horrific. The plaintiff had blisters from the acid burn and these had 'popped'. The plaintiff was immediately treated with the necessary creams and heavily sedated due to her excruciating pain. Although she was sedated she was still conscious and therefore must have experienced extreme pain during the periods when the sedation receded. She spent approximately eleven days in hospital. Eventually it was decided to take her

213 *Gibson* 1996(4) SA 129 (W)

home as it was thought that her mother could take better care of her at home than in hospital. During the initial stages of her recovery Mrs Zackie attended to the plaintiff almost round the clock. She had to change the dressings on the plaintiff's back three times daily. The plaintiff had to be helped with her ablutions and bathing. Her vagina had to be douched while sitting in the bath and on a number of occasions her mother and the plaintiff noticed dead skin being washed from the vagina. The plaintiff had to be anaesthetised whenever she wanted to pass motions and had to urinate while sitting in a bath. She was catheterised in order to keep the area as free from contamination as possible and to monitor the urine output. Throughout this period she lay prone most of the time. Her burns covered 15% of her body, taking into account the inside of the vagina and the vulva, perineum, peroneal region, and the sacrum and buttock area. A month after her admission to the second defendant's hospital on 8 October 1992 the plaintiff was admitted to the Park Lane Clinic where, under general anaesthetic, she underwent a sloughectomy of the wound on her back as well as skin grafts harvested from her buttock. She was instructed to lie prone for ten days after the operation. She was very uncomfortable in this position. The skin graft staples were removed on 13 October and two days later, on 15 October, she was discharged from the Park Lane Clinic. She was given broad-spectrum antibiotics. The scar had to be massaged with aqueous cream. By 12 November the scar was still painful and it required vigorous massaging. Silicone sheeting was applied to the scar and a corset was used over it to apply pressure on the lower back. By 3 December 1992, i.e. approximately two months after the skin-graft, the scar was still painful. On 28 January 1993 the plaintiff saw Dr Ritz again and reported that the pain had improved. She was told that further plastic surgery would be required to improve the scar. At this stage she complained of an area of breakdown in the posterior fourchette of the vagina which caused problems during intercourse. She was advised to see a gynaecologist in this regard. By 18 March 1993 Dr Ritz reported that the scar had markedly improved. It was soft and pliable but darker than the surrounding area and obvious to the observer. Dr Ritz felt essentially it was a good result. The plaintiff still had periods of pain for which she used Voltaren gel and massages. The gynaecological problem involving the posterior part of the vagina still remained unresolved, and she was again advised to see a gynaecologist. Other than that, according to Dr Ritz's report, she had healed well. Most of the perineum and the area around the vagina and the natal cleft had healed without surgical intervention. The injury left pigmentation in the skin but there was no

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

contour deformity. The donor site of the skin graft had also healed very well and was minimally noticeable. The plaintiff's mother testified that the plaintiff experienced considerable discomfort and humiliation when, during the period she had to lie prone, she was forced to pass motions in Kimbies, ie babies nappies. In fact the plaintiff was prone for approximately two months after the original incident. Part of the plaintiff's suffering was the fact that she was unable to attend to and care for her four-year-old daughter Jen-Ai. Mrs Zackie had to take over most of the plaintiff's maternal duties in looking after Jen-Ai and her household chores. Mrs Zackie testified that, subsequent to the injury, plaintiff's personality had changed substantially from an outgoing 'little tiger' and go-getter to someone who is withdrawn and depressed. The plaintiff had become like a hermit. She lost her interest in socialising, her work and her home. Where previously (as the photographs handed in as exhibits show) she wore sexy tight-fitting clothes and revealing bathing suits, she lost interest in her physical appearance. She began overeating and was forced to wear loose and unflattering clothes partly as a result of her obesity and partly due to the injuries to her back. Before returning to her work she slept three to four hours per day and did nothing but sit around, mostly at her mother's home. The plaintiff developed headaches and often complained of vaginal infections. She developed suicidal tendencies and on one occasion her ex-husband Paul cleared her home of all drugs and sleeping tablets to prevent her from taking an overdose. The plaintiff testified that she suffered extreme humiliation and indignity due to the doctors frequently examining her private parts. She felt her womanhood had been taken away. She thought that she had become infertile as a result of the injury. Sexual intercourse had become painful and troublesome. She could not be a mother to her child. She felt useless, suicidal and had nothing to live for. The only reason why she did not commit suicide was for the sake of her daughter. After the initial healing period and by December 1992 she returned to her work, doing half-day stints. Eventually she was able to do a full day's work again. She was employed at Sage Life. Prior to the injury she worked as a secretary to Mr Colin Jamieson. However, on returning to her employment she was placed in a position of what is known as a 'conservation officer', a position of lesser responsibility than that of a secretary. It appears that at Sage Life employees were subject to an annual appraisal. In the plaintiff's case her post-traumatic appraisal during April 1993 showed that she performed as 'standard' in most respects. By April 1994 her work appraisal had improved to 'good' in most respects. And by April 1995

her appraisal indicated 'outstanding' performances in seven out of twenty-two categories. Part of the plaintiff's post-traumatic suffering was actually experienced at work. She had to treat and medicate herself while at work. She was forced to take cotton wool and creams to work. Whenever she went to the toilet she had to stand over the toilet and pass motions and then clean herself with cotton wool and treat herself with the necessary creams. She also had to sit on a special chair to accommodate the pain in her back. A large portion of the plaintiff's residual physical complaints related to her alleged sexual dysfunction and recurring vaginal infections. The court took the view that the plaintiff overstated the detrimental effects of the burning incident on her sex life. According to the plaintiff she had had an active sex life of four to five episodes of sexual intercourse per week prior to the incident. Although divorced from her husband Paul during April 1992, they were staying in the same home at the time of the injury. This cohabitation was agreed to for the sake of Jen-Ai. After the injury they once again commenced sexual intercourse during or about December 1992. She in fact complained to Dr Hurwitz, a gynaecologist, on 17 December 1992 of feeling pain on penetration. Her complaint about pain to her fourchette to Dr Ritz in January 1993 is also indicative that she had recommenced having regular sexual intercourse. In February 1993 she complained to Dr Hurwitz of 'feeling raw'. However, by then her vagina had completely healed. Dr Hurwitz also found on 25 February 1993 that any discomfort she experienced was due to muscle tension in the expectation of pain and must therefore have been psychological in origin rather than physical. In October 1993 the complaint to Dr Israelstam was only of 'limited pain on introitus whereafter sex was satisfactory'. By June 1994 the plaintiff was questioned by Dr Kruger, the gynaecologist who performed an unrelated gynaecological operation on her, concerning any sexual dysfunction and she reported that there was no sexual dysfunction whatsoever. In July 1995 Dr Gordon-Grant, a gynaecologist, approached by the plaintiff, opined that any discomfort which she was suffering during intercourse was as a result of her episiotomy, ie a surgical incision of her perineum which was performed to facilitate the birth of her child, Jen-Ai.

Claasen J concluded that any sexual dysfunction she experienced as a result of the burning incident terminated approximately a year after the incident. He also concluded that although there were 11 documented complaints of vaginal infections, the plaintiff was under a misapprehension as to what caused the symptoms. It was,

however, her evidence that she at all times thought that these 'vaginal infections' were the result of the burning incident, and she was strengthened in this perception by her general practitioner's clinical findings. The objective medical evidence produced in Court, however, positively disproved the correctness of her and her doctor's conclusions in this regard. Claasen J observed that her perception that these recurring vaginal discharges resulted from the burning incident had a distinct effect on her psychological make-up subsequent to the burning incident. It strengthened her in her, albeit mistaken, perception that her womanhood was taken away from her, that she would not be able to bear children again and therefore that her marriage prospects were nil. These wrong perceptions did not help in lessening the mental anguish which was occasioned by the burning incident. He said that she could not be faulted for having entertained these wrong perceptions. Not only was she reinforced in some of them by her doctor, but no one, not one medical expert, until the trial, rid her of these wrong perceptions. Despite this unfortunate concurrence of events, said Claasen J, the defendants could not be held liable for the costs associated with the so-called 'recurring vaginal infections' because they were in truth not recurring vaginal infections at all.

Judgment

Claasen J observed that it is trite law that psychological sequelae can form the subject of a damages claim under the *lex Aquilia*[214]. He noted that it was common cause that the plaintiff was suffering from a nervous and psychological disorder known as a major depressive disorder coupled with anxiety. In this state she was unable to return to work. It became common cause that the evidence had shown that this condition is curable. A proper programme of psychotherapy and electroconvulsive therapy (ECT) commonly known as 'shock treatment', administered over a period of approximately 18 months, would restore the plaintiff to her pre-morbid level of functioning both at

214 He referred in this regard to *Bester v Commercial Union Versekeringsmaatskappy van SA Bpk* 1973 (1) SA 769 (A) at 776H-777A where Botha JA said the following: "Die betoog veronderstel dat 'n psigiatriese besering geen fisiese besering is nie, en beteken dat, ofskoon genoegdoening weens senuskok of psigiatriese besering wat tot, bv, 'n hartaanval aanleiding gee, verhaalbaar is, dit nie verhaalbaar is waar die senuskok of psigiatriese besering op, bv, kranksinnigheid uitloop nie. Voorts kom die betoog daarop neer dat 'n onregmatige dader nie aanspreeklik is vir skadevergoeding of genoegdoening waar die op-skuldige-wyse-veroorsaakte skade of persoonlikheidsnadeel binne 'n bepaalde kategorie tuisgebring kan word nie. So 'n betoog is uit die aard van die saak vreemd aan die beginsels van ons reg, en ietwat gekunsteld in die lig van die feit dat volgens die Romeins-Hollandse reg Aquiliese aanspreeklikheid sodanig uitgebrei is dat vergoeding met die *actio in factum* verhaal kan word van enige skade wat op onregmatige en skuldige wyse veroorsaak is. (*Mathews and Others v Young* 1922 AD 492 op 504.)"

home and at work. As a result of this evidence, the plaintiff's enormous claim for future loss of earnings had, to all intents and purposes, fallen away. Her claim for loss of future earnings was limited to the period of 18 months during which she would be temporarily and partially disabled from being employed. Also, her future medical expenditure was limited to the cost of undergoing the required psychotherapy and ECT which would restore her to her former level of functioning. The plaintiff contended that the defendants were liable in delict for her present depressed condition and all the costs associated therewith. The defendants contended that her present condition is not legally connected to the injury suffered in September 1992.

Claasen J observed that the defendants' negligence had been admitted. On the first trial date set for this matter, ie 16 August 1995, the defendants consented jointly and severally to judgment in respect of the allegations of negligence set out in paras 1 - 10 of plaintiff's particulars of claim. He said it was not necessary for purposes of the judgment to repeat these allegations of negligence. The nature of the injuries suffered by the plaintiff and the quantum of damages associated therewith were, however, very much in dispute. The thrust of the defendants' defence was related to the question of causation. Their defence boiled down to the contention that there was a break in the causal chain of events linking the plaintiff's present psychological state and the damages associated therewith to the original negligent acts of the defendants. Claasen J observed that it is trite law that a causal nexus between a defendant's negligent conduct and the plaintiff's damages is an essential element of delictual liability. He said that the determination whether or not certain sequelae are causally linked to the defendant's conduct requires a two-stage enquiry: Firstly, whether a factual relation exists between the defendant's conduct and the harm sustained by the plaintiff ('factual causation) and, if so, secondly, whether the defendant should be legally responsible for the harm factually caused by his conduct ('legal causation')[215]. Claasen

---

215 Claasen J noted that this process of causal determination was described by Corbett JA (as he then was) in *Minister of Police v Skosana* 1977 (1) SA 31 (A) at 34E-F in the following terms: "Causation in the law of delict gives rise to two rather distinct problems. The first is a factual one and relates to the question as to whether the negligent act or omission in question caused or materially contributed to . . . the harm giving rise to the claim. If it did not, then no legal liability can arise and cadit quaestio. If it did, then the second problem becomes relevant, viz whether the negligent act or omission is linked to the harm sufficiently closely or directly for legal liability to ensue or whether, as it is said, the harm is too remote. This is basically a juridical problem in which considerations of legal policy may play a part."
He also referred to *S v Daniëls en 'n Ander* 1983 (3) SA 275 (A) at 331B-C, where Jansen JA stated the following: "Daar kan weinig twyfel bestaan dat in ons regspraak die bepaling van "feitelike" oorsaaklike verband op die grondslag van die *conditio sine qua non* geskied. . . . Sonder sodanige verband tussen die dader se handeling en die beweerde, gewraakte gevolg is daar in die algemeen geen aanspreeklikheid nie. Aan die ander kant is dit ook duidelik dat 'n dader nie aanspreeklik gestel behoort te word vir alle gevolge waarvan sy handeling 'n *conditio sine qua non* is nie - sy

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

J stated that the test for factual causation is usually not too difficult to apply to any given circumstances. The *sine qua non* test normally results in an easy answer as to whether or not the harm would have resulted 'but for' the negligent conduct. What often poses a greater test for jurists, he observed, is the second leg of the enquiry, ie legal causation. He noted that various theories have been advanced in the past such as 'proximate cause', 'direct cause', 'foreseeability', 'absence of a *novus actus interveniens'* and 'sufficient causation'. In South Africa, he said, the matter has become settled in that the Appellate Division has laid down a 'flexible norm' ('soepele maatstaf') whereby considerations of policy, reasonableness, equity and justice are applied to the facts of the case[216]. After considering the evidence Claasen J said he was convinced that the plaintiff would not have been healed by August 1995. He said he would find it extremely strange if a young woman such as the plaintiff would not have had uninterrupted and continuous mental anguish following upon such a horrendous intrusion into her femininity. The breast and vagina have always been a symbol of womanhood and ultimate utility. It is well known that both disease and surgery of the breast and vagina evoke a fear of mutilation and loss of femininity. Injury to these organs would therefore tend to have the same consequences. It is also

---

aanspreeklikheid sou dan te wyd strek en die grense van redelikheid, billikheid en regverdigheid oorskry. Beleidsoorwegings verg dat iewers 'n grens gestel moet word."
Claasen J further noted that Corbett CJ once again had occasion to deal with the matter of causation in *International Shipping Co (Pty) Ltd v Bentley* 1990 (1) SA 680 (A) at 700E-I where the learned Chief Justice said: "As has previously been pointed out by this Court, in the law of delict causation involves two distinct enquiries. The first is a factual one and relates to the question as to whether the defendant's wrongful act was a cause of the plaintiff's loss. This has been referred to as 'factual causation'. The enquiry as to factual causation is generally conducted by applying the so-called 'but-for' test, which is designed to determine whether a postulated cause can be identified as a *causa sine qua non* of the loss in question. In order to apply this test one must make a hypothetical enquiry as to what probably would have happened but for the wrongful conduct of the defendant. This enquiry may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such an hypothesis plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the plaintiff's loss; *aliter*, if it would not so have ensued. If the wrongful act is shown in this way not to be a *causa sine qua non* of the loss suffered, then no legal liability can arise. On the other hand, demonstration that the wrongful act was a *causa sine qua non* of the loss does not necessarily result in legal liability. The second enquiry then arises, viz whether the wrongful act is linked sufficiently closely or directly to the loss for legal liability to ensue or whether, as it is said, the loss is too remote. This is basically a juridical problem in the solution of which considerations of policy may play a part. This is sometimes called "legal causation".

216 Claasen J pointed out that van Heerden JA *in S v Mokgethi en Andere* fn 74 *supra* at p 401-41B described the test for legal causation thus: "Wat die onderskeie kriteria betref, kom dit my ook nie voor dat hulle veel meer eksak is as 'n maatstaf (die soepele maatstaf) waarvolgens aan die hand van beleidsoorwegings beoordeel word of 'n genoegsame noue verband tussen handeling en gevolg bestaan nie. Daarmee gee ek nie te kenne nie dat een of selfs meer van die kriteria nie by die toepassing van die soepele maatstaf op 'n bepaalde soort feitekompleks subsidiêr nuttig aangewend kan word nie; maar slegs dat geen van die kriteria by alle soorte feitekomplekse, en vir die doeleindes van die koppeling van enige vorm van regsaanspreeklikheid, as 'n meer konkrete afgrensingsmaatstaf gebruik kan word nie." He noted that this proposition was reiterated in *Smit v Abrahams* 1994 (4) SA 1 (A) where Botha JA said at 18E-H: "Ter aanvang van die bespreking van die voorgaande betoog, ag ek dit noodsaaklik om 'n paar opmerkings van 'n algemene aard voorop te stel. Die belangrikheid en die krag van die oorheersende maatstaf om vrae van juridiese kousaliteit op te los, wat in *Mokgethi* (*supra*) en *International Shipping Co* (*supra*) aanvaar is, lê juis in die soepelheid daarvan. Dit is my oortuiging dat enige poging om aan die buigsaamheid daarvan afbreuk te doen, weerstaan moet word. Vergelykings tussen die feite van die geval wat opgelos moet word en die feite van ander gevalle waarin daar alreeds 'n oplossing gevind is, of wat hipoteties kan ontstaan, kan vanselfsprekend nuttig en waardevol, en soms miskien selfs deurslaggewend, wees, maar 'n mens moet oppas om nie uit die vergelykings-proses vaste of algemeengeldende reëls of beginsels te probeer distilleer nie. Die argument dat die eiser se eis 'in beginsel' verwerp moet word, is misplaas. Daar is net een 'beginsel': om te bepaal of die eiser se skade te ver verwyderd is van die verweerder se handeling om laasgenoemde dit toe te reken, moet oorwegings van beleid, redelikheid, billikheid en regverdigheid toegepas word op die besondere feite van hierdie saak."

well known in cases of rape that women suffer ruminatory thoughts for extended periods of time after the incident. In his view the plaintiff's injuries far exceed the injuries normally associated with rape. The burning of her back, the skin-grafting operation, the humiliation of her inability to do her ablutions in a normal manner, her fear of being infertile and the continued medical examinations which she was subjected to, constitute, in his opinion, added suffering which was not normally associated with the trauma of rape. It is therefore more than probable that the plaintiff, given her immature personality traits, would have taken a long time to overcome the psychological trauma associated with the violation of her genitals. Claasen J said that if he was correct in drawing this analogy with the trauma normally associated with rape, then it was probable that she would have suffered continuous mental anguish throughout the period leading up to the court case in August 1995. He found that even though plaintiff's condition may have been influenced by 'compensation neurosis', this in itself would not break the chain of causality, absolving the defendants[217].

Claasen J said that trial stress in itself cannot therefore break the causal chain between the defendants' negligence and the plaintiff's present major depressive disorder. He stated that taking into account reasonableness and equity, he was of the view that the present condition was justifiably linked to the defendant's negligence. Her present worsened depressive disorder, he said, was not harm of an altogether different kind from that which one would normally expect after an injury of the kind suffered by the plaintiff. A more severe form of depression, ie a major depressive disorder plus anxiety, following upon a burning of a woman's genitals is not an unexpected phenomenon. Claasen J stated that it was not a result of 'a different kind from that which would otherwise have resulted from the actor's negligence' (per Hiemstra J in

---

217 He referred in this regard to *Moehlen v National Employers' Mutual General Insurance Association Ltd* 1959 (2) SA 317 (SR) where Morton J said at 319H-320C: "If, then, anxiety neurosis is the sole cause of her present condition, this litigation and the plaintiff's desire for compensation are not its only causes, though they may have intensified it. It was initially caused by her physical injuries and was a direct and reasonably foreseeable consequence of the deceased driver's negligence. This puts the present case in a very different class from such cases as *Hay (or Bourhill) v Young* [1942] 2 All ER 396, and *King v Phillips* [1953] 1 All ER 617, which Dr Palley has cited in support of his submission. Whether I apply the test of foreseeability to the negligence only, as in the *Polemis* case, [1921] 3 KB 560, or extend it to the consequential damage, the result is the same, and I find the defendant liable for that damage. Similar anxiety neuroses have been held to be ground for damage in such cases as *Latimer v Orient Steam Navigation Company Ltd* (1952) and *MacKenna v Smiths Dock Company and Others* (1947), the reports of which are only available to me in Kemp and Kemp's *The Quantum of Damages* at 367-70. In *Slipman v London Transport Executive* (1951) ibid at 361, in which the plaintiff had suffered no physical injury at all in the collision and in which there was a similar conflict of medical opinion, Mr Justice Hilbery, although he preferred the diagnosis of the medical witness for the defendant that the plaintiff would recover and that settlement of his claim would have enabled him to recover very much quicker, nevertheless awarded substantial general damages."

Alston and Another v Marine & Trade Insurance Co Ltd[218]. It was a normal response to the stimuli created by the negligent injury to the plaintiff, particularly so because of her neurotic state of learned helplessness and her inherent personality traits. This was merely a case of a young woman who was incapable of facing the results of her injuries with 'normal' fortitude and courage. In essence her vulnerability stemmed from the weakening effect which her pre-existing personality traits had on her ability to withstand trauma. Hers was a 'thin skull' case in the emotional and psychological sense. That being so, it seemed to Claasen J that her emotional over-reaction to the stimuli emanating from these additional stressors could not be regarded as a supervening cause and the defendants must be held liable. The court said that it must be remembered that her *sequelae* stemmed from actual physical injury to herself. It was not a case of merely witnessing a traumatic event which induced shock causing subsequent psychological sequelae. In cases where psychological *sequelae* follow after actual physical injury, there is less likelihood of 'limitless' liability and therefore greater scope for a flexible approach to include liability for psychological *sequelae* which are further removed from the original negligent conduct.

Claasen J held that even if it could be said that there was a lesser connection between the nervous collapse during August 1995 and the original injury, the fact that she was physically injured would be sufficient in these circumstances to hold the defendants liable. Because the plaintiff suffered physical injury, she was to be regarded as a 'primary victim'. He noted that in *Page v Smith*[219] Lord Keith held that the thin skull rule applies where the plaintiff is a primary victim (as was Mrs Gibson in the present matter). He held that hindsight has no part to play where the plaintiff is a primary victim and proof of proximity will therefore present no problem, i.e. remoteness of damages will not be a problem where psychological *sequelae* occur consequent upon a physical injury. Claasen J said that the principle expressed by Lord Keith is in line with the dictum of Botha JA in Bester's case. He was of the opinion that the clarity and perspective which hindsight brings in regard to the respective influences of all the stressors which played a part leading up to the August 1995 psychological collapse, was not that relevant where the defendants' negligence caused the plaintiff to suffer a direct physical injury. He held that the thin skull rule applied. The defendants

---

218 *Alston* 1964 (4) SA 112 (W) at 116F-G)

219 *Page* [1995] 2 All ER 736 (HL) at 767 *in fine*

therefore found their victim as she was with all her personality traits which played an important although unquantifiable role in causing the collapse. The defendants also found the plaintiff with all her built-in stresses and strains arising out of her family-related problems. Claasen J sad that it was not possible to quantify the influence of these stressors and thus the fact that the collapse occurred later rather than sooner was with hindsight of little consequence[220]. Applying these principles to the present case Claasen J was of the opinion that the defendants were liable for all forms of nervous shock and psychological trauma, the lesser as well as the more serious, following after the injury because it is irrelevant whether the precise nature and extent of plaintiff's psychological trauma could have been foreseen.

It was submitted for the defendants that had the plaintiff submitted to timeous psychotherapy she would have received timeous cognitive restructuring which would have returned her to her pre-morbid emotional level of functioning. This would then have enabled her to withstand the trial stress and its associated disappointments. Claasen J responded to this by saying that it must be remembered that the onus to prove that the plaintiff acted unreasonably in failing to submit herself for psychotherapy, rests on the defendants[221]. Claasen J observed that it was never the defendants' case at the commencement of proceedings that the plaintiff's alleged failure in this regard constituted a *novus actus interveniens* which broke the causal chain between the defendants' negligence and the ultimate psychological breakdown in August 1995. Nor was this defence pleaded. He said he was about the true nature of this defence asking if he was to hold that the plaintiff negligently failed to submit to psychotherapy, should her negligence be regarded as contributory negligence or should her negligence be taken into account when legal causation is evaluated? He asked whether it was truly a defence of a *novus actus interveniens* interrupting legal causation or was it a defence of contributory negligence by the plaintiff which caused her damages to be reduced by apportionment? If the latter, then the plaintiff's

---

220 Claasen J associated himself with what Berman AJ said in *Masiba and Another v Constantia Insurance Co Ltd and Another* 1982 (4) SA 333 (C) at 342D-F: "Regard being had to the physical condition of the deceased and his long history of hypertension the present case affords an almost classic instance of the so-called 'thin skull case', the rule being that a negligent defendant is bound to take his victim as he finds him, see *Wilson v Birt (Pty) Ltd* 1963 (2) SA 508 (D) at 516. It being a sine qua non of liability where non-physical injury is inflicted that this harm should have been foreseeable, the application of the 'thin skull rule' to cases involving injury of this nature is that once a psychiatric injury of gravity sufficient to render it actionable is foreseeable, then the injured party can recover for more extensive psychiatric damage which is attributable to his pre-existing weakness, see Bester's case *supra* at 779." He also referred to the Australian cases referred to by Navsa J in *Clinton-Parker v Administrator, Transvaal*; *Dawkins v Administrator, Transvaal* 1996 (2) SA 37 (W) at 65H-66F.

221 *Butler v Durban Corporation* 1936 NPD 139 at p 148

damages may be reduced due to her contributory negligence only if the pleadings placed her fault in issue[222] which, in this case, the pleadings did not.

Claasen J noted that on the pleadings it was common cause that the defendants were 100 % to blame for the plaintiff's injuries. What was in issue, on the pleadings, was the nature, extent and quantum of her damages consequent upon her injuries. But, he observed, it has been held that 'fault' as used in section 1 of the Apportionment of Damages Act[223] is wide enough to bear the extensive meaning of negligent conduct which causally contributed to both the occurrence of the 'harmful event' as well as negligence which affects the 'nature, extent and quantum of damages' suffered. He observed that this was held to be so even in cases where the defendant's negligence is the sole cause of the harmful event. The plaintiff's 'fault' which may help to cause both the harmful event and the subsequent nature and extent of his damages, said Claasen J, is restricted to 'pre-accident' or 'pre-tortious' fault. Put differently: it is the plaintiff's negligent conduct prior to the commission of the defendants' delict which is judged as being relevant for purposes of apportioning the plaintiff's damages, and not his negligent conduct after the commission of the delict. Thus a plaintiff's negligent conduct subsequent to the harmful event which caused his damages cannot be the subject of apportionment in terms of the Apportionment of Damages Act[224].

Claasen J found that a distinction should be drawn between the parties' negligence prior to the harmful event and any relevant negligence after the harmful event. In the case of a plaintiff, his pre-delictual negligence will trigger the application of contributory negligence to reduce his damages. The plaintiff's post-delictual negligence will, however, affect the principles of legal causation (or remoteness) which may reduce his damages. Post *delicto*, the plaintiff's negligent conduct may be regarded as an *actus novus interveniens* which breaks the chain of causality

---

222 *AA Mutual Insurance Association Ltd v Nomeka* 1976 (3) SA 45 (A) at 55-6

223 Apportionment Act 34 of 1956

224 The court referred to Neethling J and Potgieter JM 'Aspekte van die Deliks Elemente Nalatigheid, Feitelike en Juridiese Kousaliteit (insluitend die sogenaamde eierskedelgevalle) – Smit v Abrahams' (1993) *THRHR* 157 at p 159: "Die wesenlike verskil tussen die vraag na nalatigheid (juridiese verwytbaarheid van die dader) aan die een kant, en kousaliteit (aanspreeklikheidsbegrensing of toerekenbaarheid van skade) aan die ander kant, moet nie uit die oog verloor word nie. Dit is onlogies om, nadat eenmaal bevind is dat die dader nalatig was (omdat hy in die lig van die voorsienbaarheid van óf spesifieke gevolge, óf skade in die algemeen, anders moes opgetree het), met verwysing na verdere ('remote') gevolge weer te vra of die dader anders moes opgetree het. Daar is immers by die ondersoek na nalatigheid reeds besluit dat hy anders moes opgetree het. By verdere gevolge gaan dit dus nie meer om die dader se verwytbaarheid (skuld) nie (dit staan in hierdie stadium reeds vas), maar of hy vir die verdere gevolge van sy verwytbare optrede aanspreeklik gehou moet word."

sufficiently to absolve the defendants from liability for the plaintiff's damages. It is therefore in terms of the doctrine of legal causation (and not contributory negligence) that he chose to construe the defence of the plaintiff's alleged refusal to submit to psychotherapy. Also, said Classen J, the fact that this defence was not pleaded by the defendants would be no bar to it being considered. Any defence which attacks the legal connection between the harmful event and the plaintiff's damages can be raised once the nature, extent and quantum of the plaintiff's damages have been put in issue. On the evidence, Claasen J found that this defence must fail. It was never explained to the plaintiff in detail what a full-blown psychotherapeutic programme could mean to her. The cost and time implications were never discussed with her, nor the expected prognosis if she were to submit to such a course. It was only after the full analysis contained in Dr Sugarman's medico-legal report came to hand for purposes of the trial that these facts were made available to the plaintiff. It was therefore not correct to say that she 'refused' psychotherapy. Nor did she 'unreasonably' refuse to undergo psychotherapy said Claasen J.

As far as damages were concerned, Clasasen J held that taking into account the plaintiff's pain and suffering, disfigurement and loss of amenities of as well as the comparable cases to which counsel had referred and allowing for some inflationary escalation, a proper award for plaintiff's general damages for pain, suffering, disfigurement, and loss of amenities of life, past and future, should be an amount of R70 000.

Discussion

This case is an example of the thin skull rule applied in the psychological rather than the physical context. Since, as the court has pointed out, the nervous system is in any event a physical component of a person's psychological state, there is no reason in principle why the thin skull rule should not be applied to psyschological harm. The court acknowledged the 'thin skull rule' in psychological as opposed to physical harm in *Clinton-Parker v Administrator, Transvaal Dawkins v Administrator, Transvaal*[225].

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

It is submitted that this view is consistent with the constitutionally acknowledged right to psychological integrity. It is important to note in this regard that where a mishap occurs due to an underlying and undetected condition, for example an allergy to anaesthetics, this will not necessarily mean that the provider is liable for that mishap. All of the elements of delict, including negligence are still a requirement. If the provider should have anticipated the underlying condition and, for example, asked the patient if he or she suffered from any allergies or if there are certain recognised pretests to be conducted where there is a reasonable likelihood that a patient could have an underlying condition then it is likely to be evidence of negligence where such precautions were not taken.

9.2.14 Broude v Mcintosh And Others[226]

Facts

The appellant was a medical doctor who has spent most of his professional life practising medicine either privately or as an employee of a hospital. He was born on 30 March 1931 and was 60 years of age at the time of the operation. In 1969 his left ear began to trouble him. He experienced deafness and tinnitus and protracted bouts of giddiness. In the same year he underwent an operation in Germany. It left him permanently deaf in the left ear but alleviated the tinnitus and the vertigo to such an extent that for 20 years he had no need of further intervention. In 1989 there was a recurrence of vertigo and tinnitus with accompanying nausea. He was referred in 1990 to the first respondent, Professor McIntosh, who was an ear, nose and throat surgeon. He was head of the relevant department at the Johannesburg hospital and a professor in the faculty of medicine of the University of the Witwatersrand. Conservative treatment followed but brought little relief. In March 1991 a decision was made to operate. The operation was performed by the first respondent at the Johannesburg General Hospital on 4 September 1991. The operation which the first respondent set out to perform was a cochlear vestibular neurectomy. It was a designedly destructive operation and had as its object the severance of both the cochlear and the vestibular nerves. The vestibular nerve is severed and excised to counteract vertigo. The cochlear nerve is severed but not necessarily removed to counteract tinnitus.

---

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

Inasmuch as the cochlear nerve plays a role in the hearing function, its severance would not have been appropriate if the plaintiff had still been able to hear in his left ear. The operation entails gaining access to the inner ear structures by making appropriate incisions, sculpting away with a rotary burr part of the mastoid bone behind the ear, passing through the labyrinth and of the cochlea (and *en passant* destroying them *pro tanto*) and arriving at the internal auditory canal. This is a bony structure with an internal lining of dura which is a very thick tough tissue. The bone of the canal is shaped down until it is so translucent that one can see through it to the structures behind it. The underlying dura is exposed by lifting the remaining film of bone. The dura is then opened and the nerves which are to be severed are exposed to view. They are visualised microscopically at a very large magnification by the surgeon. Absent any anatomical abnormalities the nerves are easily seen and distinguished from one another both by reason of their colouration and by reason of their physical location and the courses which they take. In close proximity to the vestibular and cochlear nerves is the facial nerve - indeed these three nerves make contact with one another for some of their respective lengths. The vestibular nerve has two branches both of which are severed and a segment of each removed. The cochlear nerve is incised and may or may not be removed. To close the opening through which entry was gained, a sheet of fascia (fibrous tissue which holds structures together and envelops muscles) taken from the patient's body is placed in such a way as to cover the opening in the internal auditory canal. To hold it in place and provide a soft tissue seal so that cerebrospinal fluid which fills the canal does not exude or leak out, an appropriate quantity of body fat harvested from the patient is eased into the cavity before the incision in the patient's skin is sutured. That is how the first respondent said the operation should be done and there was no disagreement amongst the medical witnesses about that.

The operation was done and after spending some time in the recovery room appellant was taken to the ward in the latter part of the morning. His wife was waiting to see him. According to first respondent, the appearance and function of the appellant's face after he awoke from the anaesthetic in the recovery room was normal. Later that day when he saw the appellant in the ward there were no clear signs of even a partial palsy. All that he observed was 'a possible sluggishness of movement in places'. According to the appellant's wife, Mrs Broude, she noticed when appellant was

wheeled into the ward that 'his face looked strange' in that his mouth looked 'skew'. She said that the appellant passed his hand across his face and asked her whether his face was skew and she replied in the affirmative. Later on in the afternoon she met the first respondent in the ward which was a general ward. The appellant asked the first respondent whether his face was skew and first respondent affirmed that it was. The first respondent allegedly patted her on the shoulder and laughingly said: 'Mrs Broude, if you were in America you would already be at the lawyer's offices.' According to first respondent he said no such thing. Appellant and his wife also said that first respondent told them that appellant's face would return to normality within three to four weeks. First respondent's version was that when he did discuss the palsy (and it was not on that occasion) he said it would resolve itself in three to four months but that he could have said that it might resolve itself earlier within a matter of weeks.

The first respondent did not dispute that by the next day some clinical signs of a left facial palsy were visible. On that day the appellant was tested by means of electroneuronography to establish the status of his facial nerve. The test (ENOG) showed a 60% degeneration of the nerve. On 19 September (by which time appellant had been re-admitted to hospital another ENOG was carried out and it showed a 100% degeneration of the nerve.

During the appellant's first stay in hospital there was a leakage of cerebrospinal fluid through the surgical wound and through the nose. The occurrence of such a leak is not uncommon and is not necessarily or even probably indicative of negligence. The appellant was anxious to go home and after discussion with the first respondent during which appellant was told to stay in bed he was discharged. There was still an occasional leak of cerebro-spinal fluid at this time. While at home appellant suffered from a stuffy and irritating nose. He blew his nose and experienced an excruciating headache. He rushed back to hospital and remained there for several days. When he was subsequently discharged, the appellant was to be strictly confined to his bed, take antibiotic cover, and report back regularly to the department. The leakage of cerebrospinal fluid continued. The first respondent's attitude was that it would stop of its own accord. The appellant decided to take a second opinion and consulted Dr Davidge-Pitts on 7 October. The appellant was advised to wait for a few more weeks. He also communicated with Dr Hamersma during October. The latter was reluctant to

be involved but advised him to keep in contact with the first respondent, to be conservative and to follow the first respondent's advice. By 23 October the leak had stopped and appellant returned to work on 28 October.

On 29 October the appellant consulted an ophthalmologist, Dr Kuming, about problems he was experiencing as a consequence of not being able to open and close his left eye because of the palsy. As time went by and no improvement in his facial condition appeared to be taking place, appellant's anxiety increased. He experienced difficulty in making contact with the first respondent and eventually appellant wrote to him. The letter was mainly reproachful. It was said that the facial palsy was still present and the question was posed whether the facial nerve had been either partially or completely severed. Surprise and disappointment was expressed that neither first respondent nor his department had made contact with the appellant. However, first respondent was thanked for everything and the operation was said to be 'in a final analysis' a 'success' and 'the nursing, medical and hospital' were said to have been 'superb'.

The first respondent claimed not to have received this letter until long after it was written, citing his lengthy absence from South Africa as one of the reasons why he did not receive it sooner. He admitted that he did not reply to it but said that he was due to see appellant soon after he had seen the letter and intended to discuss it with him then. As a fact they did not see one another again. On 30 January 1992 appellant consulted a neurologist, Dr Levy, who was well known to him. Clinical examination failed to disclose any observable functioning of the left facial nerve. An electromyographical (EMG) test was performed to assess whether any function was present. According to Dr Levy mild volitional activity in certain of the facial muscles was noted. No stimulation of the facial nerve was possible. Dr Levy concluded that there did appear to be some return of function and suggested that a further EMG test in six weeks' time might be of some value. He said in evidence that the volitional activity reflected when the EMG test was done was inconsistent with total severance of the nerve and that for the message to have reached the muscle from the brain stem via the facial nerve meant 'that there must have been some continuity' and that whatever lesion there might be was a 'partial' one. He said that clinical recovery of a facial nerve can be very delayed and that electrical recovery often precedes clinical recovery. However,

there is sometimes no functional recovery. A further test was carried out on 1 July 1992 but the findings were not recorded and Dr Levy was quite unable to recall what they showed. Appellant claimed that he had been told by Dr Levy that the result of the first test was equivocal and that nothing could be deduced from it. Dr Levy's response to that was that the result of the test may have been equivocal as an indicator of returning function but that it was not equivocal as an indicator of continuity of the nerve.

Before returning to Dr Levy on 1 July 1992 the appellant consulted Dr Hamersma during February 1992 after an arranged meeting with first respondent did not take place on 4 February. Dr Hamersma examined appellant and subjected him to electrical testing. He told the appellant that the facial nerve was dead and that there was no response. He questioned the appellant about his interaction with the first respondent and, having learnt that the first respondent had told appellant to await developments, he advised him to 'err on the conservative (side) and give it its best shot' seeing that the first respondent had 'never ever indicated any kind of concern' and that 'we should wait up till nine months'. He also told him that he might need an operation and that he should consult another ear, nose and throat surgeon, Dr Le Roux, and a neurologist, Dr De Klerk. On 5 March 1992 Dr Kuming performed a tarsorrhaphy operation on appellant. It entails suturing the corners of the eyelids together in order to protect the eye without depriving the patient of the use of the eye. Had appellant been able to open and close his left eye this operation would not have been required.

On 19 May 1992 appellant consulted Dr Le Roux who sent him to a physiotherapy practice conducted by Ms Melanie Jacobs in the same building in order to undergo a nerve excitability test (NET). The test was conducted by one of her assistants, Ms Van der Merwe. According to Ms Van der Merwe, she had no difficulty in performing the test. The apparatus was not out of order and appellant was not told to come back on another day. According to Dr Le Roux, the result indicated that the nerve was alive and had a chance of recovery and that it had not been severed. Marais JA observed that a strange feature was that Dr Le Roux testified initially that he had not asked for the test to be done but conceded when confronted with a note written to Ms Jacobs that he had done so. However, he said he had received no report on the result of the

test. When asked why he had not asked for the report when it was not forthcoming, he was quite unable to explain why he had not done so. He claimed to have seen it for the first time in court. Equally strange, said Marais JA, was the appellant's evidence that the apparatus was not functioning, that he returned on another day to be tested, and that the person conducting the test was still 'not very impressed with their apparatus' but said 'they have got some result and that they would report to Dr Le Roux'.

The latter advised appellant that he should consider going to see Dr Fisch, a renowned surgeon in Zurich, with a view to surgical exploration of the nerve and a primary nerve repair. Dr De Klerk shared that view. In the result the appellant was operated upon by Dr Fisch in Zurich on 19 September 1992. Dr Fisch was unable to repair the nerve and instead performed a facial nerve hypoglossal anastomosis. The operation entails severing the nerve to the tongue in the neck and then connecting it to the facial nerve where it exits from the brain stem at the base of the skull. The muscles of the face are thereby enervated and the patient is trained to use the tongue to create facial movement. However, it does not restore emotional expression and while it is possible to close the eye, secretion of the eye does not return and the eye remains dry. The operation was successful.

The appellant underwent yet further operations in South Africa in 1993 to improve his facial appearance. What was found during the operation in Zurich and what inferences could be drawn from what was found was the subject of much debate. Dr Hamersma was present at the operation and described what was found. Dr Fisch did not testify but his note of the operation was translated from German into English and placed before the trial Judge by consent of all the parties as being a correct exposition of what he did and what he found. The parts of it around which debate centred were these:

"5. Behind the *foramen meatal*, a huge neuroma bulged out of the opened internal auditory canal. This neuroma was removed by tympanoplasty scissors, without escaping of fluid.

6. Removal of bone over *jugular bulbus* in the area of *porus acusticus internus*. This had not been reached by previous operation. Exposure of back, upper and lower surfaces of the internal auditory canal. The facial nerve was traced

inside the scarred auditory canal. A few millimetres before the *foramen meatal*, the nerve loses itself inside scar tissue. The scar extends over the entire internal auditory canal

7. Opening of the meatal dura in the area of porus acusticus internus. Here too an atrophied facial nerve was to be found. Even after removal of dense scar tissue from the internal auditory canal, it was still impossible to identify a proximal stump of the facial nerve, with any certainty. It would appear that, after the previous operation, dense scar tissue in the internal auditory canal compressed the facial nerve and led to development of a scar-neuroma.
8. In view of the fact that facial paralysis had persisted for one year and the patient's facial muscles had a very flaccid appearance, we decided to proceed with a hypoglosso-facial-anastomosis.

Review: The cause of the facial-nerve-lesion during the previous operation remains unclear. It is possible that the internal auditory canal was, to a large extent closed by tissue which, as a result of post-operative swelling of facial nerve graft within the inner auditory canal was compressed and, as a result, regenerated nerve-fibres were unable to establish contact with the meatal foramen. Whether the six weeks of liquorrhea also were (also) responsible, remains an open question."

Marais JA noted that what was thought to be a neuroma was shown on histological examination to be 'scar tissue with parts of a peripheral nerve'. A neuroma is the new growth of tissue which usually follows upon the severance of a nerve and it is something quite distinct from scar tissue. The reference to 'liquorrhea' was a reference was to the leakage of cerebrospinal fluid which occurred in September 1991.

Judgment

The claim for damages was founded upon first respondent's conduct before, during, and after the operation. Marais JA found that the omission to inform appellant of the risk of leakage of cerebrospinal fluid was of no significance. The leakage was not proved to be causally related to the onset of the facial palsy and the appellant did not claim that if the risk of leakage had been mentioned to him, he would have refused to

consent to the operation. Marais JA observed that the court *a quo* drew attention to the fact that when the appellant's letter of demand was sent it made no mention of any failure by first respondent to inform appellant of the risk to the facial nerve and the availability of an alternative operation. The judge in the court *a quo* also considered it to be improbable that first respondent would have failed to inform appellant of these matters. Marais JA added that it was also somewhat improbable that the appellant would have been disinterested in such matters given the fact that he was a medical practitioner with some knowledge of the anatomy of the area in which the operation would be performed. He held that no good reason existed to differ from the trial judge's view that this cause of action was not made out and that the same applied to the alternative cause of action based upon an alleged negligent failure to inform appellant.

The negligent conduct during the operation was pleaded originally as consisting of, firstly, the severance of the facial nerve, and, secondly, the failure properly to close the operation site and the aditus (entrance) to the antrum (cavity). The latter allegation was not persisted in at the trial and no more need be said about it. During the trial appellant amended his pleadings to include an allegation that, if the facial nerve was not severed, it was negligently damaged in some other unspecified way. The trial judge concluded that the evidence did not establish on a balance of probabilities that the facial nerve was severed during the operation. Marais JA after considering the basis for the trial judge's conclusion held that there was no preponderance of probability that the facial nerve was severed during the operation. Counsel for the appellant contended that, whatever the precise cause of the palsy was, the onset of the palsy was so immediate and complete that it had to be inferred, as a matter of probability, that it could only have been caused by some unspecified negligent act on the part of the surgeon which caused damage so severe that the act must have been closely akin to severance in its traumatic impact. In considering this contention Marais JA noted that the evidence of Dr Hamersma was of pivotal importance in the appellant's case and that the trial judge's mainly unfavourable assessment of him as a witness was fully borne out by the evidence. He was found to be deserving of credit for his readiness to champion the cause of the appellant but lacking in objectivity because of his professional animosity towards the first respondent which predated the operation which the first respondent performed upon the appellant. Marais JA said

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

that a disturbing aspect of his evidence was the zeal with which he sought to persuade Dr Fisch to include in his report an unequivocal statement to the effect that the cochlear nerve had not been cut despite the fact that the factual foundation for such a statement was slender. His motive for doing so was to enable it to be argued that the facial nerve had been mistaken by first respondent for the cochlear nerve and mistakenly severed. A perusal of his evidence, said Marais JA, showed him to be a forceful and at times excitable personality who was intent upon dredging up anything he could think of which might reflect adversely upon the first respondent's performance of the operation, his conduct after the operation, and his credibility. Anything which appeared to militate against his own thesis of severance of the facial nerve or damage so serious as to be akin to severance was dogmatically derided as being of no consequence. Marais JA concluded that while Dr Hamersma was a very knowledgeable and experienced surgeon and there was much in his evidence which made good sense and accorded with the evidence of other medical witnesses and medical literature, there were too many manifestations of a lack of objectivity to enable one to repose any real confidence in him as a witness. His dogged persistence in advancing the contention that first respondent had negligently severed the facial nerve during the operation, knew that he had done so, yet failed to lift a finger to make amends, was, in the face of the countervailing indicia and the inherent improbability of such behaviour, illustrative of unjustifiable obstinacy and cast a pall of doubt over the value of his evidence on other contested issues. Marais JA noted that counsel for the appellant had frankly conceded that, if the finding that it had not been proved that an immediate and total left facial palsy had set in after the operation could not be successfully assailed, he would find it very difficult, if not impossible, to convince the court that it was more probable than not that first respondent must have been negligent in some or other respect in performing the operation. Marais JA said that this concession was correctly made and that even if the immediate onset of a total facial palsy had been proved, it would have been questionable whether the inference that first respondent had negligently seriously traumatised the facial nerve during the carrying out of the operation would have been justified. Marais JA stated that in cases of this kind, when a patient has suffered greatly because of something that has occurred during an operation a court must guard against its understandable sympathy for the blameless patient tempting it to infer negligence more readily than the evidence objectively justifies, and more readily than it would have done in a case not

involving personal injury. He said that any such approach to the matter would be subversive of the undoubted incidence of the onus of proof of negligence in South African law in an action such as this. The judge observed that when reviewing the total picture emerging from the evidence, counsel for appellant sought to invest with some significance what the trial Judge found to be untrue denials by the first respondent of what at first blush might seem to be compromising statements made by him after the operation (the reference to medical malpractice litigation in the United States of America and the long wait for recovery of facial function which would be appellant's lot). It was argued that, when read with the difficulty which the appellant said he experienced in getting to see or elicit any response from first respondent after his discharge from hospital, it was indicative of a guilty conscience and a realisation that the operation had not been performed with the necessary care. Some significance was also sought to be attached to the finding that first respondent's description of the appearance of appellant's face soon after the operation was unjustifiably euphemistic. Marais JA further observed that the trial Judge weighed these contentions and discounted the probative value of the findings on which they were based. He pointed out that the remark about lawyers and the United States of America was equally consistent with a genuine sense of confidence that at worst a transient facial palsy which would soon resolve itself was present. The overheard remark, made on a later occasion, that it would take longer to recover than appellant had initially been led to believe, when objectively regarded, is not indicative of any sense of personal guilt. The difficulties experienced by appellant in making contact with first respondent were not regarded as sinister. The evidence on that issue was rightly held to be inconclusive. The euphemistic description by first respondent of appellant's face was not attributed by the trial Judge to a wilful perversion of the truth; instead he attributed it to reconstruction based upon available but incomplete hospital records and assumptions about what would have been done. He pointed to the inherent improbability of first respondent having known all along that he had severely damaged the facial nerve but having refrained from informing appellant and, more importantly, from having taken any remedial operative action. Recriminations and unpleasant repercussions would be inevitable. Although he did not explicitly say so, Marais JA said he thought that it was implicit in the trial Judge's judgment that, whatever reason first respondent may have had for denying making the remarks which he did, the inference that it was because he had a guilty conscience was not justified.

It was argued that the learned trial Judge's assessment of first respondent's credibility was unduly charitable and that reconstruction and inadequate hospital records could not explain his excessively euphemistic description of appellant's facial appearance soon after the operation. Nor, so it was submitted, could a subconscious repression of any recollection of the statements which he made after the operation satisfactorily account for his denial that he made them. Marais JA said whilst this may be so he did not think that it contributed greatly to the resolution of the question of whether first respondent was indeed negligent in his performance of the operation. Marais JA found that he was unable to say that the trial Judge was wrong in his overall assessment of this aspect of the case.

Marais JA stated that the post-operative negligence alleged could be disposed of shortly. An allegation that the appellant was prematurely discharged from hospital on the fifth day after the operation 'in a debilitated and ill condition' was said by the appellant himself to be incorrect. An alleged negligent failure to institute any or proper treatment for a 'dry eye' condition which often accompanies facial palsy had to be jettisoned when it became quite obvious from contemporaneous hospital records, the authenticity of which was undisputed, that appellant's evidence in support of that allegation was quite wrong. An allegation that there was a negligent failure to close the cerebrospinal fluid leak was simply not shown by the evidence. It stopped of its own accord as both the first respondent and Dr Davidge-Pitts had predicted it would. An allegedly negligent failure to properly monitor the appellant's condition by regular check-ups or examinations was not established. As the trial Judge correctly observed, the preponderance of evidence was that it was expected of a public hospital patient to report back after his discharge. A report back date had been mentioned upon appellant's first discharge. It was anticipated by his second re-admission to hospital when the cerebrospinal leak worsened. Upon appellant's second discharge there was nothing to be done except to wait. Indeed, said Marais J, despite the appellant's later resort to other medical practitioners for advice (including Drs Le Roux and Hamersma), no immediate surgical intervention was advised and they too advised appellant to wait and see what developed. By the time surgical intervention was recommended, the appellant had long since ceased to look to the first respondent for treatment and advice. An allegedly negligent failure to inform appellant that he had severed the facial nerve and to determine the site of the damage to the nerve and

repair it was not proved because a severance of the facial nerve during the operation was not proved. The appeal was dismissed with costs.

Discussion

It is submitted that this case serves to illustrate the point that not all adverse outcomes following a medical intervention attract liability. It also could be cited in evidence of the lack of truth behind the idea of a conspiracy of silence between health professionals since the expert witness for the plaintiff seemed so determined to expose the defendant's lack of professional skill that he even went almost so far as to try to construct evidence to this effect himself. Fortunately the court was not deceived on this score. The question of expert medical evidence and how the courts approach it is covered in some detail in the discussion of *Michael v Linksfield Park Clinic infra*. In *Broude* the question was primarily around causation althoughof course negligence was also alleged but not proven. There was no evidence that the facial nerve of the plaintiff had been severed in the operation neither was there sufficient evidence of negligence on the part of the defendant. It would seem that the overly emotional and vindictive responses of the expert witness for the plaintiff did not assist the latter's case because the court acknowledged the pivotal importance of this expert witness but also recognised his lack of neutrality.

9.2.15 Mukheiber v Raath[227]

Facts

Mr and Mrs Raath were married out of community of property and both were estate agents. Mrs Raath had given birth to four children: a son, Zane, who was born in 1986 and who died when he was five years old; a son, Timothy, born in 1988; a daughter, Taryn, born in 1993; and a son, Jonathan, born in 1994. The birth of Jonathan gave rise to the claim. Dr Mukheiber was a gynaecologist who had been practising as such for more than 30 years. A doctor-patient relationship existed between him and Mrs

227 *Mukheiber* 1999 (3) SA 1065 (SCA). See Scott TJ 'The Definition of Delictual Negligence Revisited: Three Judgments of the Supreme Court of Appeal 2000 *De Jure* 33 358 and Neethling J and Potgieter JM 'Deliktuele Aanspreeklikheid Weens Bevrugting as Gevolg van Nalatige Wanvoorstelling: Die Funksies van Onregmatigheid, Nalatigheid en Juridiese Kousaliteit Onder Die Loep' 1999 (3) SA 1065 SCA'2000 *THRHR* 162

Raath from before Timothy's birth, attended to by Dr Mukheiber and done by way of caesarian section in 1988. In 1992 Mrs Raath became pregnant with Taryn. Dr Mukheiber once again was chosen by the prospective parents to attend to the pre-natal treatment of Mrs Raath. She visited him a number of times in the ordinary course of her confinement. On 28 January 1993 Mrs Raath again visited Dr Mukheiber on a routine ante-natal gynaecological visit. During the course of that visit it was decided that she would give birth to the child she was then carrying by elective caesarian section on 8 February 1993, which was to be done by Dr Mukheiber. During the course of the same consultation, she informed him that she did not wish to fall pregnant again and the question of sterilisation was raised. Dr Mukheiber informed her that he required her to discuss the matter with her husband and to tell him at their next consultation what they had decided. Mr and Mrs Raath had previously discussed the prospect of her sterilisation but not in depth. They did not, on the evening of 28 January 1993, discuss the issue of sterilisation. However, during the early hours of 29 January 1993 Mrs Raath went into spontaneous labour and, at approximately 6.30 am, Dr Mukheiber delivered her of a healthy daughter (Taryn) by emergency caesarian section. The following day Dr Mukheiber visited Mrs Raath in hospital and on Monday, 1 February 1993, she was discharged from hospital. At no stage was it agreed that Dr Mukheiber would perform a sterilisation procedure. The prescribed forms required by the hospital where Mrs Raath gave birth to Taryn that permit a doctor to perform a sterilisation had not been completed. The pathological examination which Dr Mukheiber always insisted upon after he had done a tubal ligation had not been requested or done. He had, in fact, not performed a sterilisation on Mrs Raath and his patient's card and records did not reflect such an operation at all, although meticulously correct in all other respects.

The cause of action arose on 4 February 1993, when Mrs Raath, accompanied by her husband, visited Dr Mukheiber's consulting rooms and surgery at approximately 13:00 to have the sutures, inserted during the caesarian section, removed. The plaintiffs' version was that, having removed the sutures, Dr Mukheiber called Mr Raath, who was in the waiting room, into the surgery to show to him how neatly the operation had been done. According to them, Dr Mukheiber then told them that he had performed a sterilisation on Mrs Raath, that she was now a 'sports model', and that they did not need to worry about contraception. Dr Mukheiber disputes this

version. He cannot remember having removed Mrs Raath's sutures, but concedes that he must have done so. However, he denies that he ever made the alleged misstatement. He said he did not think he had made a mistake [ie the alleged misrepresentation] for the following reasons: it was very soon after the caesarian section, six days, and he remembered the procedure very, very clearly. The second thing that was uppermost in his mind would have been the fact that when he phoned the Libertas Hospital [just before the emergency caesarian] he asked the sister to please inquire from Mrs Raath if she wanted to be sterilised. If she wanted to be sterilised she should get consent from her and her husband. And the third thing is that he would have had my clinical notes in front of him as well as a pathological report, and if he had seen a pathological report then he would have known that she had had a sterilisation. But if there was no pathological report he could not possibly see how he could have made that mistake.

During August 1993 Mrs Raath telephoned Dr Mukheiber and informed him that she was not feeling well and that her menstrual periods had stopped. She asked him whether it was possible to fall pregnant after a sterilisation, and that he replied that it was highly unlikely and that, in more than 30 years of practice, he had never had a sterilisation that had gone wrong because he cuts, ties and cauterises the Fallopian tubes. According to her he said that she was probably overworked and that it was more likely that her hormones had not yet settled down after the sterilisation. Dr Mukheiber admitted in evidence to a telephonic conversation with Mrs Raath in August 1993. According to him she asked him whether a person who had been sterilised could possibly fall pregnant, to which he replied that it was highly unlikely but that anything was possible. He denied that she accused him of doing a sterilisation on her and denied having told her that, in performing a sterilisation, he also cauterises the Fallopian tubes - that is not his practice. He also denied having told her that he had never had a failed sterilisation, because, in fact, he had had two such failures. He also denied telling her that it was likely that her hormones had not yet settled down, because a tubal ligation would not affect the hormonal balance at all. On 21 September 1993 Mrs Raath visited a general practitioner, Dr Andrea Steinberg, who diagnosed that she was 12 weeks pregnant. Mrs Raath testified that she was devastated and burst into tears, because they did not want to have more children. Dr Steinberg (who was not available to testify) telephoned Dr Mukheiber and the latter

then spoke to Mrs Raath over the telephone. According to her, he said that he was '. . . absolutely flabbergasted . . .' to learn that she was pregnant, because he cuts, ties and cauterises the tubes and that there must be some technical problem. He requested her to come and see him the following day in his surgery. Dr Mukheiber recalled the telephonic conversation with Dr Steinberg. He testified that it was put to him that he had sterilised Mrs Raath and that she was now three months pregnant. He testified that this was the first time that he had been accused of having performed a sterilisation on Mrs Raath. His evidence is that he said to Dr Steinberg that he did not have his clinical notes with him, but that he would check his notes the following morning, which he did. He also telephoned the records department of the Libertas Hospital and ascertained that only a caesarian section had been performed and no sterilisation.

Mrs Raath testified that she visited Dr Mukheiber the next day, ie 22 September 1993. Her evidence is that he called her into his surgery and told her that he had not done a sterilisation on her. She replied that he had told her that he had done a sterilisation, whereupon, in her words, he said:

" . . . he knows he told me, he was mistaken but he was too lazy to check his records at that time. He said that he felt morally responsible about what had happened, and asked me what I wanted him to do about it."

After Mrs Raath, according to her evidence, explained to him that they had no medical aid assistance, Dr Mukheiber undertook not to charge her for the future ante-natal care and caesarian section itself, but stated that she would have to pay the hospital fees. Dr Mukheiber recalled this consultation with Mrs Raath. He flatly denied that he told her that he had made the alleged misrepresentation or that he had made a mistake and had been too lazy to consult his notes. He admitted not having charged Mrs Raath for the consultation, but denied that it indicated guilt. According to him he did so for compassionate reasons. He conceded that it is possible that for compassionate reasons he also undertook to attend to the prenatal care and the delivery free of charge. Mrs Raath did not use Dr Mukheiber's professional services

after this date. They commenced litigation shortly thereafter. The trial Court absolved the defendant, Dr Mukheiber, from the instance with costs[228].

The Full Court of the Cape High Court reversed the trial Court's judgment. Accepting that Mrs Raath *bona fide* believed that a sterilisation had been performed on her by Dr Mukheiber (which belief was never questioned during the trial), the Full Court found it inconceivable that such belief might have been due to some delusion or confusion of which no suggestion whatsoever was made during her cross-examination. The Court found it 'highly improbable' that anyone other than Dr Mukheiber, or any actual or imaginary incident or circumstance not suggested or referred to in evidence, might have conjured up the firm belief in her mind that she had been sterilised. The probabilities rather favour the inference that Dr Mukheiber must have sown the seed in the minds of the Raaths that they could discontinue contraceptive practices.

Judgment

Olivier JA observed in giving judgment that since the middle of the 1960s actions for 'wrongful conception' (an action for damages brought by the parents of a normal, healthy child born as a result of a failed sterilisation or abortion performed by a medical doctor), 'wrongful birth' (an action brought by the parents on similar grounds but where the child is born handicapped) and 'wrongful life' (an action brought by a deformed child, who was born as a result of a negligent diagnosis or other act by a doctor) have troubled Courts in England, the USA, Canada and Germany. In South Africa it was for the first time given judicial attention in the High Court in *Edouard v Administrator, Natal*[229] and by this Court in *Administrator, Natal v Edouard*[230]. The *Edouard* case was a claim for 'wrongful conception' and was based on breach of contract.

---

228 Olivier JA noted that the crux of the decision was formulated as follows: "It follows from the aforegoing that I find myself in the unenviable position of not being able to decide the probabilities on either side. I cannot find that the general probabilities favour plaintiffs' case more than defendant's, or vice versa. As far as the credibility of the witnesses is concerned, I cannot fault the evidence of either side to the extent that I would reject their evidence as being untrue. In the result, I am unable to find that plaintiffs have discharged the onus upon them of establishing that defendant made the alleged misrepresentation that he had sterilised first plaintiff."

229 *Edouard* 1989 (2) SA 368 (D)

230 *Administrator Natal v Edouard* fn 197 *supra*

Olivier JA observed that the legal matrix in which the plaintiffs' claim was to be placed and judged is that of negligent misrepresentation which cause pure economic loss, ie as opposed to physical injury to person or property, and not made in a contractual context. Such a claim, he noted, is recognised in South African law as one of the instances of the application of the extended *actio legis Aquiliae*[231]. He stated that the action is available to a plaintiff who can establish:

(i) that the defendant, or someone for whom the defendant is vicariously liable, made a misstatement (whether by commissio or omissio) to the plaintiff;
(ii) that in making the misstatement the person concerned acted unlawfully;
(iii) that such person acted negligently;
(iv) that the plaintiff suffered loss;
(v) that the said damage was caused by the misstatement; and
(vi) that the damages claimed represent proper compensation for such loss.

Olivier J noted that the court had in the past cautioned against the danger of limitless liability produced by the application of the extended Aquilian action. That danger, he said, is ever present, particularly where a medical practitioner runs the risk of having in effect to maintain the child of his patient without having any real control over the vicissitudes that attend the child's upbringing. In order to keep the cause of action within reasonable bounds, each and every element of the delict should be properly tested and applied[232]. Olivier J noted that the danger of limitless liability in particular as far as negligent misrepresentation as a cause of action is concerned can be averted if careful consideration is given to the dictates of public policy, keeping in mind that public policy can easily become 'an unruly horse'.

Olivier JA said that he was not inclined to reject the doubt or to reject the trial Court's finding as to the credibility of the three dramatis personae. He agreed, however, that on the evidence the probabilities favoured the case of the Raaths and that that, on a balance of probabilities, it had been proved that Dr Mukheiber did make the alleged

---

231 This principle was first recognised in *Administrateur, Natal v Trust Bank van Afrika Bpk* 1979 (3) SA 824 (A) at p 831B-833C. The action was again affirmed in *Siman and Co (Pty) Ltd v Barclays National Bank Ltd* 1984 (2) SA 888 (A) at p 904D-G, again in *Lillicrap, Wassenaar and Partners v Pilkington Brothers (SA) (Pty) Ltd* 1985 (1) SA 475 (A) at p 498D-in *Bayer South Africa (Pty) Ltd v Frost* 1991 (4) SA 559 (A) at 568B-D.

232 This includes, according to Corbett CJ in *Bayer* [fn 193 *supra*] at 568D ". . . the duty of the Court (a) to decide whether on the particular facts of the case there rested on the defendant a legal duty not to make a misstatement to the plaintiff (or, to put it the other way, whether the making of the statement was in breach of this duty and, therefore, unlawful) and whether the defendant in the light of all the circumstances exercised reasonable care to ascertain the correctness of his statement; and (b) to give proper attention to the nature of the misstatement and the interpretation thereof, and to the question of causation".

representation. He pointed out that Mrs Raath was not sterilised by Dr Mukheiber when he performed the caesarian section on her on 29 January 1993. The representation by him that he had done so was therefore false. On the subject of unlawfulness, Olivier JA stated that there are different ways in which the unlawfulness of a misrepresentation can be approached. Common to all approaches is the fundamental principle that tortious liability is founded not upon the act performed by the defendant, but upon the consequences of that act[233]. He noted further that common to all approaches is that unlawfulness, in the relevant sense, is to be found in the violation of the rights of the person suffering damage as a consequence of the act complained of, and that whether or not there was a violation of a right of the claimant (or the converse, a dereliction of a duty by the defendant) depends on a number of considerations, including in the final instance, public policy[234]. Olivier JA observed that the South African legal position relating to the unlawfulness of a misrepresentation was admirably encapsulated by Corbett CJ in an article entitled 'Aspects of the Role of Policy in the Evaluation of our Common Law'[235] Olivier JA stated that the question of whether there is a duty not to make a misrepresentation, depends on the circumstances of each case[236]. He said that in the context of misrepresentation one must ask the question: was there in the particular circumstances an invasion of the rights of the claimant as a consequence of the misrepresentation? Conversely, was there a legal duty upon the defendant before making the

---

233 He quoted Viscount Simonds in *Overseas Tankship (UK) Ltd v Morts Dock and Engineering Co Ltd* [1961] 1 All ER 404 (PC) (Wagon Mound No 1) at 415A: "But there can be no liability until the damage has been done. It is not the act but the consequences on which tortious liability is founded. Just as (as it has been said) that there is no such thing as negligence in the air, so there is no such thing as liability in the air." He also referred to Boberg (fn 86 *supra*) at 31.

234 *Suid-Afrikaanse Uitsaaikorporasie v O'Malley* 1977 (3) SA 394 (A) at 403A; *Schultz v Butt* 1986 (3) SA 667 (A) at 679A-F; *Regal v African Superslate (Pty) Ltd* 1963 (1) SA 102 (A) at 121G-122F; *Minister van Polisie v Ewels* (fn 66 *supra*) at 596G-597H).

235 Corbett CJ (1987) 104 *SALJ* 52 at 59. He said it bears full quotation: "Thus the key to liability is the existence of a legal duty on the part of the defendant, that is the person making the statement, not to make a misstatement to the plaintiff, that is the person claiming to have been damnified by the statement. For without this legal duty there can be no unlawfulness. And unlawfulness is a sine qua non of Aquilian liability. The legal duty is, however, not an absolute one. It simply requires the defendant to take reasonable care to ensure the correctness of his statement before making it. This requirement of a legal duty, together with the nature of the misstatement and its interpretation, and the question of causation, enables the Courts to keep within bounds the potentially unruly concept of liability for economic loss caused by a negligent misstatement. In deciding to give its imprimatur to this cause of action, the Appellate Division unquestionably took a policy decision of paramount importance in the law of delict. Moreover, as in the case of liability for an omission, the general test adopted for determining wrongfulness or unlawfulness poses the question whether in all the circumstances of the case there was a legal duty to act reasonably. The application of this test in each individual case, where there is no clear precedent, entails the making of a further policy decision, or value judgment. Here the law must keep in step with the attitudes of society and consider whether on the particular facts society would require the imposition of liability. Factors which would no doubt influence the Court in coming to a conclusion would be whether the extent of the potential loss incurred is finite and identifiable with a particular claimant or claimants; whether the misstatement relates to a field of knowledge in which the defendant possesses or professes skill; whether the misstatement was made in a business or professional context or merely casually or in a social context, whether the loss suffered was a reasonably foreseeable consequence of the misstatement; and so on."

236 *King v Dykes* 1971 (3) SA 540 (RA) at 546A-E.

representation, to take reasonable steps to ensure that it was correct? He found that the following circumstances indicated that there was such a duty:

(i) The relationship between Mrs Raath (and her husband) and Dr Mukheiber and the nature of his duties towards them amounted to a special duty on his part to be careful and accurate in everything that he did and said pertaining to such relationship.

(ii) The representation was not only objectively material, carrying the real, objective risk of the conception and birth of an unwanted child; the representation was also subjectively material: the dangers of a false representation of the kind under discussion should have been obvious to the mind of a gynaecologist in the position of Dr Mukheiber.

(iii) It was plain that the misrepresentation induced the Raaths not to take contraceptive care.

(iv) It must have been obvious to a person in Dr Mukheiber's position that the Raaths would place reliance on what he told them, that the correctness of the representation was of vital importance to them, and that if it were incorrect they could suffer serious damage.

(v) The representation related to technical matters concerning a surgical procedure about which the Raaths as lay people would necessarily be ignorant and Dr Mukheiber would, or should be, knowledgeable.

A failure on a doctor's part to take reasonable steps to desist from making the sort of representations now under discussion unless and until he has taken all reasonable steps to ensure the accuracy of the representation would, said Olivier JA, render the misrepresentation unlawful.

He then turned to the question of negligence and noted that in South African law, the standard of conduct expected from all members of society is that of the bonus paterfamilias, ie the reasonable man or woman in the position of the defendant. An act which falls short of this standard and which causes damage unlawfully is described as negligent, ie it is tainted with *culpa*. Olivier JA stated that the test for *culpa* can, in th light of the development of the law since *Kruger v Coetzee*[237] be stated as follows:

---

237 *Kruger* 1966 (2) SA 428 (A)

For the purposes of liability *culpa* arises if -

(a) a reasonable person in the position of the defendant -

(i) would have foreseen harm of the general kind that actually occurred;

(ii) would have foreseen the general kind of causal sequence by which that harm occurred;

(iii) would have taken steps to guard against it, and

(b) the defendant failed to take those steps.

He observed that in the case of an expert, such as a surgeon, the standard is higher than that of the ordinary layperson and the Court must consider 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[238]. Dr Mukheiber did not dispute that, if it was found that he had made the representation under discussion, his action was negligent. Applying the tests set out above, it was clear, said Olivier JA, that Dr Mukheiber should reasonably have foreseen the possibility of his representation causing damage to the Raaths and should have taken reasonable steps to guard against such occurrence, and that he failed to take such steps.

On the subject of causation, Olivier JA made the following observations. As far as factual causation is concerned, the court follows the *conditio sine qua non* - or 'but for'- test[239]. Once factual causation has been established, however, the question of limiting the defendant's liability for the factual consequences of his or her conduct arises. It is here that views differ radically. There are two main schools of approach amongst South African academic writers and in the case law.

The 'relative view'[240] proposes that one should -

". . . see both wrongfulness and culpability, not in abstracto, but as relative to the actual consequences in issue. The question is not whether the defendant's conduct was wrongful and culpable, but whether the harm for which the plaintiff sues was caused wrongfully and culpably by the defendant. Wrongfulness is determined by applying the criterion of objective reasonableness *ex post facto* to the actual harm and the manner of its occurrence; culpability is satisfied only where the defendant intended or ought reasonably to have foreseen and guarded against harm of the kind that actually occurred. Having thus accorded the requirements of wrongfulness and fault an active role in the limitation of liability, those who adopt this approach have no need to postulate a further requirement that the plaintiff's damage be not 'too remote'. Their finding that the defendant acted wrongfully and culpably in causing the harm actually complained of inherently also confines his liability within acceptable limits. And the policy considerations that must ultimately determine what limits of liability are

238 *Van Wyk v Lewis* (fn 3 *supra*) at 444.

239 *Minister of Police v Skosana* fn 215 *supra* at 34F-35G

240 Boberg (fn 20 *supra*) at p 381

acceptable receive due judicial recognition when the discretionary 'objective reasonableness' test of wrongfulness and the flexible 'foreseeable kind of harm' test of negligence are applied."

The other view

". . . is that limitation is best achieved by postulating a further requirement for liability, namely that the plaintiff's damage must not be 'too remote'. Also called 'legal causation', remoteness may be determined in various ways. Some favour the 'direct consequences' test, some the 'foreseeability' test, some the 'adequate cause' test and some a composite solution. Common to all, however, is the premiss that culpability is an 'abstract' attribute of conduct unrelated to its actual consequences, and so having no function in limiting liability for those consequences, which is the province of 'legal causation'. The traditionalists therefore approach the issue of remoteness already armed with a wrongful and negligent act that has in fact caused harm, and proceed to enquire whether the causal connection is sufficient - according to the test that each favours - to found legal liability."

In general, said Olivier JA, the courts have in the past on occasions followed the relative approach. Among others, Boberg[241] has pleaded for a rejection of the second approach on the grounds that-

"the need to have recourse to remoteness is a self-imposed burden of those who refuse to see that negligence, being a failure to act as a reasonable man would have done in particular circumstances, cannot be divorced from those circumstances and therefore contains all the ingredients for the effective limitation of liability."

Nevertheless, he said, the court of appeal has applied the test of so-called legal causation in recent times on more than one occasion, and counsel for Dr Mukheiber had relied on these cases[242] for his argument that the damages claimed by the Raaths, or part of it, are too remote and should either be refused *in toto* or limited. Olivier J stated that what appears from the 'legal causation' cases is that public policy plays a role, even a decisive role, in limiting liability. On the other hand, in the relative approach, public policy plays the very same role in establishing which consequences of an act are to be regarded as wrongful, thus creating and at the same time limiting liability. The two approaches differ in methodology and approach, but not in substance. If properly applied, they would generally give the same legal result in each case. What is clear in the present case is that the element of factual causation, the 'but

241 Boberg *The Law of Delict* at p 382

242 The cases are *Minister of Police v Skosana* (fn 215 *supra* at p 34) (Corbett JA, majority judgment); *International Shipping Co (Pty) Ltd v Bentley* fn 215 *supra* at p 702 *et seq* (Corbett CJ); *Smit v Abrahams* fn 216 *supra* at p 14A *et seq* (Botha JA); *Standard Chartered Bank of Canada v Nedperm Bank Ltd* 1994 (4) SA 747 (A) at 764I et seq (Corbett CJ); *Groenewald v Groenewald* 1998 (2) SA 1106 (A) at P 1113C-J.

for' test, is not in issue: but for Dr Mukheiber's misrepresentation, the Raaths would have taken contraceptive measures, and the child, Jonathan, would probably not have been conceived and born. What remained in dispute is whether public policy excludes or limits the liability of Dr Mukheiber in the present case. The role and ambit of public policy in a claim by the father of a normal and healthy child conceived and born after an unsuccessful tubal ligation performed on his wife, the mother of the child, against the doctor was considered by this Court in *Edouard*. The action was based on breach of contract. Damages were claimed for (a) the cost of supporting and maintaining the child up to the age of 18 years and (b) for the discomfort, pain, suffering and loss of amenities of life suffered by the mother. This Court disallowed claim (b) on the basis that in our law general damages of the type claimed under this head are not recoverable in a breach of contract action. Claim (a) was upheld. In upholding claim (a), the court undertook an extensive review of overseas cases and legal literature dealing with claims for 'wrongful conception', 'wrongful birth' and 'wrongful life' in the context of public policy. Van Heerden JA, with whose judgment the other four Judges concurred, found (at 589F-G) that the majority of the objections against the said type of claims are based on no more than two basic themes pertaining to public policy, viz-

"(i) that the birth of a normal and healthy child cannot be treated as a wrong against his parents, and (ii) that as a matter of law the birth of such a child is such a blessed event that the benefits flowing from parenthood as a matter of law cancel or outweigh the financial burden brought about by the obligation to maintain the child. Thus it has been suggested in somewhat florid language that the birth of a healthy child is an occasion for the popping of champagne corks rather than for the preferring of a claim for damages."

As far as objection (ii) is concerned, Van Heerden JA held that it is simply not the position in South African law that benefits of a non-pecuniary nature can be subtracted from patrimonial loss. Van Heerden JA dismissed objection (i) with equal decisiveness[243]. But, asked Olivier JA, are the policy considerations underlying the decision of the court in *Edouard* also applicable to the present dispute? He stated there are differences which cannot simply be glossed over. The first and obvious is

---

243 Van Heerden JA said ". . . the 'wrong' consists not of the unwanted birth as such, but of the prior breach of contract (or delict) which led to the birth of the child and the consequent financial loss. Put somewhat differently, the Bundesgerichtshof has succinctly said that, although an unwanted birth cannot as such constitute a 'legal loss' (i.e. a loss recognised by law), the burden of the parents' obligation to maintain the child is indeed a legal loss for which damages may be recovered." Van Heerden JA quoted, with approval, dicta from the dissenting opinion of Clark J in *Cockrum v Baumgartner* 447 NE 2d 385 (1983) at 392-3; the dissenting opinion of Cadena J in *Terrell v Garcia* 496 SW 2d 124 (1973) at p 131 and the judgment in *Jones v Malinowski* 473 A 2d 429 (1984) at p 435.

that while *Edouard* dealt with contractual liability, the present case involved a delictual claim. In *Edouard*[244] van Heerden JA, in dealing with the nature of the wrong complained of, indicated that the wrong consists of the prior breach of contract or delict which led to the birth of the child and the consequent financial loss. Olivier JA said he considered this approach of the law to be correct. There can be but one test for wrongfulness, based as it is ultimately on considerations of public policy, and whether the claim is brought in contract or delict. He noted that it is well recognised today that a contract between a patient and a doctor imposes on the latter a duty to exercise due care and skill; but even in the absence of a contract between them there is a duty of care on the doctor. The duty of care in either case seems inevitably to be measurable by the same yardstick and Olivier JA was of the view that the same policy considerations that underlie the *Edouard* judgment are applicable in the appeal under consideration. These considerations, he said, did not stand in the way of allowing the Raath's action.

Secondly, there is the question of the underlying motive of the mother (and the father) for not wanting a child to be conceived and born. After discussing the dicta of Thirion J in *Edouard*[245], Olivier JA stated that he could see no reason for limiting claims such as those under discussion to requests made only by married couples (what of the spinster or widow who needs the operation for preventative medical reasons?) or where the husband has given his consent (is a woman not in control of her own body?) or where the request is made for socio-economic reasons only (which may be the worst reason: what if it is requested for reasons of health - the father or mother is HIV positive - or there is a genetic defect in the family, etc?). In the present case the Raaths did not wish to have any more children for socio-economic and other family reasons. He found that these were socially acceptable reasons, and that it did not lie in

---

244 *Edouard* fn 197 *supra* at p 590F

245 In *Edouard* in the Court *a quo* (fn 229 *supra*), where the claim was of contractual nature, Thirion J at 375I came to the conclusion that "...an agreement for a sterilisation operation to be performed on a married woman with her husband's consent where the reason for the operation is the prevention of the birth of a child whom they would be unable to support, is valid". In dealing with the arguments pro and contra the recognition of an action for damages based on breach of contract in respect of wrongful birth, Thirion J limited himself to claims of parents in a wrongful birth action for damages in respect of the expense which the parents will have to incur in connection with the maintenance of the child born, as a result of the breach of contract to perform the sterilisation operation "...and where the reason for their seeking sterilisation was the couple's inability to maintain the child. Different considerations might well apply where the consideration influencing the decision to have the operation was not an economic one." When the appeal in *Edouard* was adjudicated in the SCA, Van Heerden JA also concluded his remarks by stating that his finding (that the claim was admissible) was intended to pertain "... only to a case where, as here, a sterilisation procedure was performed for socio-economic reasons. As pointed out by Thirion J [in the court *a quo*] different considerations may apply where sterilisation was sought for some other reason".

the mouth of Dr Mukheiber to say that he is not liable because the Raath's reasons for not wanting a child were not legitimate or *contra bonos mores*.

Olivier JA pointed out that a third problem in the present type of case was the fear of imposing too heavy a burden on the doctor. In contract, the doctor can contract out of liability. While generally it is not impossible or *contra bonos mores* to contract out of delictual liability, it is difficult to see how it could realistically have been done in the present case. He held that the response to the fear expressed above must rather be that professional people must not act negligently. In casu, they should not make unsolicited misrepresentations[246]. A fourth problem was: how far was Dr Mukheiber's liability to go? As far as the confinement cost was concerned, there could be no defence: such costs were reasonably foreseeable and there was no reason to limit them. The problem arose, said Olivier JA, in connection with the maintenance claim. The cost of maintaining the child, Jonathan, was a direct consequence of the misrepresentation. It was foreseeable by a gynaecologist in Dr Mukheiber's position. In principle he was by virtue of considerations of public policy, not protected against such a claim, as pointed out above. But the claim cannot be unlimited. His liability could be no greater than that which rests on the parents to maintain the child according to their means and station in life, and lapses when the child is reasonably able to support itself.

In the result, he was of the view that considerations of public policy did not militate against holding Dr Mukheiber liable for compensating the Raaths for the damages claimed by them. The appeal was dismissed with costs.

Discussion

Roederer[247]criticises the Supreme Court of Appeal's characterization of this case as being one of 'pure economic loss'. He points out that the actual harm entails an infringement of the right to choose, resulting in a combination of potential patrimonial and non-patrimonial harms and benefits. He states that one may say here that the harm

246 In this regard Olivier JA referred to Bruce Cleaver 'Wrongful Birth' - Dawning of a New Action' (1991) 108 *SALJ* 47 at p 66.

247 Roederer CJ 'Wrongly Conceiving Wrongful Conception: Distributive v Corrective Justice' (2001) 118 *SALJ* 347

has been mislabelled and the result of the mislabelling is that the courts could not fashion a remedy to repair the harm. Further, he says that they were at least precluded from thinking how a potential remedy could deter the future creation of the harm. He also questions whether or not the facts actually establish a negligent misrepresentation on the basis of the extent to and manner in which it is justifiable for a court on appeal to take a trial court's findings of fact and reinterpret them, set them aside and further exclude facts from being entered into evidence. Roederer asserts that the full bench and the Supreme Court of Appeal did not develop the law by boldly fashioning a new rule or creating a new legal action and that while they did rule favourably on an extension of Aquilian liability to a new factual situation, the facts as found by the trier of facts do not fit the rule. He argues, nonetheless, that considerations of distributive justice mandated some form of relief in this case and notes that such considerations are not easily at home in the law of delict which is much more hospitable to notions of corrective justice. He says that Aquilian liability with its underlying logic of corrective justice does not allow easily for a remedy on the facts as found by the trial court. While there is a simple straightforward remedy for negligent misstatements or misrepresentations causing pure economic loss, there is no simple, uncomplicated remedy for negligent miscommunications or misunderstandings causing loss of the right to choose whether or not to conceive.

It has been stated that in *Mukheiber v Raath* the appeal court, through the mouth of Olivier JA, reopened the old debate on the limitation of liability in the law of delict[248]. Potgieter notes that over the last ten years or so, especially since the judgment of Van Heerden JA in *S v Mokgethi*[249] a degree of consensus has developed that legal causation should serve as a measure of liability, Mukheiber, with reference to Boberg, once again revives the so-called relative approach as an alternative method to legal causation of limiting legal liability. He notes that according to the strict application of the relative approach, the question as to the boundaries of liability must be resolved during the investigation into unlawfulness and negligence and a separate investigation of legal causation is therefore unnecessary. He notes that this discussion is further

248 Potgieter J 'Gedagtes oor die rol van onregmatigheid, nalatigheid en juridiese kousaliteit in die deliktereg' *Acta Juridica* 2000 p 67. For further criticism of Mukheiber see Neethling J and Potgieter JM 'Deliktuele Anspreeklikheid Ween Bevrugting As Gevolg Van 'n Nalatige Wanvoorstelling: Die Funksies van Onregmatigheid, Nalatigheid en Juridiese Kousaliteit Onder Die Loep' (2000) 63 *THRHR* 162

249 *Mokgethi* fn 74 *supra*

developed in *Sea Harvest Corporation (Pty Ltd v Duncan Dock Cold Storage (Pty) Ltd*[250]. He points out that in *Mokgethi,* the appeal court advocated that use of the so-called supple approach to the question of legal causation. According to this approach, the critical question is whether there is a sufficiently close connection between the acts of the doer and the consequence with respect to policy considerations on the grounds of reasonableness, fairness and justice. Potgieter notes that the traditional tests for legal causation such as the 'direct consequences', foreseeability and adequate cause tests can play a subsidiary role in the determination of legal causation in terms of the flexible approach. He points out that this approach has been followed and developed in numerous authoritative appellate division and high court decisions and, contrary to the impression given in *Mukheiber*, there is little doubt as to the content thereof. He says that according to Mukheiber there are in principle two approaches to the limitation of a tortfeasor's liability, namely the so-called relative approach according to which legal causation is unnecessarily taken into account because unlawfulness and negligence are established with reference to each head of damages, and legal causation which, as a separate element of a delict, determines the attribution of damages to a tortfeasor independently of unlawfulness and negligence. He notes that in both approaches, public policy plays, according to the court the exact same role – namely to limit liability (and, in the context of unlawfulness, to simultaneously create liability) – and will in general in any event yield the same result.

In order to ascertain whether the defendant in *Mukheiber* should be held responsible for the particular consequences, the court did not expressly select one of the two approaches but addressed itself directly to 'public policy' without indicating whether this was with regard to unlawfulness or legal causation. Potgieter complains that this had the result of blurring to some extent the distinction between unlawfulness, negligence and legal causation. On top of this, he says, legal causation as an independent element of the law of delict is shifted to the background because the court did not follow the comprehensive appellate division judgement on the subject but apparently relied solely on Boberg's outdated position that legal causation should be abandoned in favour of the relative approach. Nonetheless says Potgieter, it seems

250 *Sea Harvest* [2000] All SA 128 (SCA)

as though the court in the end took into account policy factors which fall within the ambit of legal causation.

Potgieter comments that the decision of the appeal court in *Mukheiber* can put a question mark on the value and importance of legal causation as an independent element of a delict and can promote legal uncertainty. He says that this is already partially evident in *Sea Harvest* where, with reference to *Mukheiber*, the majority of the court through the judgment of Scott JA dealt with the question of the limitation of liability by means of the relative approach to negligence while Streicher JA in a minority judgment applied legal causation as it was developed in *Mokgethi*. He notes that certain aspects of *Mukheiber* have attracted criticism elsewhere[251] and briefly repeats some of this criticism in order to provide accompanying commentary. He states that firstly it seems as if the court erroneously found that negligence was present before unlawfulness was established. The court postponed the final verdict as to unlawfulness to the point where finality as to the role of certain policy considerations was obtained, a question which the court only answered after the question of negligence had been resolved. In actual fact, fault - the legal blame attributed to the defendant – is only determined if it is certain that he acted unlawfully – a position which judge Olivier himself stated on occasion expressly[252] Potgieter observes that any question there might have been that in *Mukheiber* that the appeal court wrongly found that there was negligence before it was clear that unlawfulness was present, was dispelled in *Sea Harvest*. There the court found unabashedly that unlawfulness only arises once negligence has been established. Scott JA in giving the majority judgment stated: "In the absence of negligence the issue of wrongfulness does not arise." Potgieter observes that it requires no argument that this viewpoint, in the words of Olivier JA in *Administrateur Transvaal*, is based on a legal impossibility and is therefore unacceptable.

Boberg's position, as reflected in *Mukheiber* – that the relative approach that unlawfulness and negligence are determined simultaneously with liability – is a

---

251 Neethling J and Potegieter JM, fn 248 *supra*

252 *Administrateur Transvaal v Van der Merwe* 1994 (4) SA 347 (A) 364: "'n Bevinding dat appellant se late nie onregmatig was, bring mee dat daar geen sprake van nalatigheid kan wees nie. Nie alleen is dit dus ondoenlik om oor moontlike nalatigheid aan die kant van appellant to spekuleer nie, maar dit is trouens juridies onmmoontlik. Die nalatigheid kan naamlik beantwoord word as presies vasstaan welke regsplig op 'n verweerder gerus het en dat *daardie* regsplig verbreek is"

typical example, says Potgieter of the faulty use of particularly negligence instead of legal causation, as a means of limiting liability. It is clearly nonsensical to apply the reasonable foreseeability and avoidance test for negligence to the question of liability of the defendant for the wider consequences. He says that it is illogical after it has already been found that a person has acted negligently (because in the light of reasonably foreseeable consequences he should have acted differently) to ask again with reference to further consequences whether the person should have acted differently. It has already been decided that he should have acted differently[253]. From this it follows, says Potgieter, that the test for negligence is not suited to determine liability for the wider consequences and that a purpose built, independent criterium is necessary to achieve this objective. That legal causation is concerned with a completely different question to fault is underlined by the need to apply legal causation to cases of strict liability where no fault is present. The apparent conclusion of the court in *Mukheiber* that both the defendant's liability and the boundaries thereof can be determined purely by way of public policy without indicating which delictual element is under discussion is open to criticism because it causes confusion between amongst others unlawfulness and legal causation. Potgieter comments that certain policy considerations are more appropriate to certain delictual elements than others. He states that this can be illustrated particularly with reference to one policy consideration namely that the defendant's liability should not be unbounded so that the fear of possibly unlimited liability can be avoided. Usually the judgment – apparently under the influence of the English duty of care approach – weighs the possibility of limitless liability against the question of whether there was a legal obligation on the defendant to avoid the relevant pure economic loss (or to supply the correct information in the case of a negligent misrepresentation), in other words, the question of unlawfulness. Potgieter observes that this method of approach is however questionable on solid grounds. According to van Aswegen[254] it would be a better

---

253 He refers *inter alia* to Hart H and Honoré AM *Causation in the Law* (1959) p 239-40 in which the authors state: "There is a logical absurdity in asking whether the risk of further harm, arising from a harmful situation which a reasonable man would not have created, would itself have deterred a reasonable man from acting."

254 Van Aswegen A 'Die Sameloop van Eise on Skadevergoeding uit Kontrakbreuk en Delik' (LLD thesis, UNISA) (1991) p 177-8; 'Policy considerations in the law of delict' 1993 *THRHR* 192-3. Van Aswegen, as quoted by Potgieter, states: "Ten aansien van die bepaling van die regsplig, dit wil sê onregmatigheid [by suiwer ekonomiese verlies] speel veral twee beliedsfaktore 'n belangrike rol, naamlik die moontlikheid van oewerlose aanspreeklikheid en die subjektiewe wete of kennis van die dader. Op die oog af lyk dit of die twee faktore albei aanvaarbare beliedsfaktore is wat by vasstelling van onregmatigheid ter sprake kan kom. Nietemin kom dit my voor of die feit dat te wye skade of skade van onbeperkte omvang deur bepaalde optrede veroorsaak word, nie sodanige optrede sonder meer regmatig behoort te maak nie. Ek twyfel of dit strook met die gemeeskapsordende funksie van die privaatreg. Een van die onwendslike konsekwensies van so 'n houding is dat geen interdik verkry sou kon word teen dreigende veroorsaking van oewerlose suiwer ekonomiese verlies nie. Myns insiens sou 'n beter oplossing wees om so 'n oorweging by die juridiese kousaliteitsvraag in

solution to take such a consideration into account when looking at the question of legal causation by finding that there is an insufficiently close connection between the action and the ultimate result, namely unlimited liability. Then such loss causing behaviour would still be unlawful while the doer's liability would be kept within reasonable bounds. Potgieter states that according to Boberg, adherents to the legal causation approach believe that legal causation takes over completely the limiting function and that negligence has no function in limiting liability. Potgieter points out that in the first place, recognition of legal causation as a delictual element is not inextricably bound to the purely abstract approach to negligence in accordance with which negligence is established solely by means of the question whether loss in general was foreseeable. Even where a more concrete approach to negligence is chosen above the abstract approach, legal causation in specific cases has a role to play. Secondly, he says, it is not correct to describe legal causation as the only means of limiting liability. The boundless liability which factual causation in itself would contribute is in a sense already bounded by the liability determining elements of a delict. In this way the liability of a person who causes loss factually but who does not act unlawfully, or who acts unlawfully but is not negligent is bounded by the absence of the elements of unlawfulness and fault. Legal causation comes expressly to the fore when it appears that a person's actions with reference to at least certain consequences are unlawful and at fault but there are further consequences that arise and the question is whether he must be held responsible for those further consequences. Because the application of legal causation as a means of limiting liability is not necessarily based on the purely abstract approach to negligence, says Potgieter, it is more correct to refer to the two approaches as the relative (or concrete) approach and the legal causation approach. Put this way, it is not completely clear in *Mukheiber* to which of these two approaches the court leans. He notes that the court refers to both but then declares that these approaches in effect are the same and if correctly applied, yield the same results in view of the fact that public policy plays the same role in both. Oliver JA then proceeds to adjudicate liability purely on the basis of public policy without expressly indicating the delictual element to which it relates. As previously indicated, it looks as if the court is still busy with the question of unlawfulness. On the other hand, a person could say that the court nevertheless dealt with the question of liability

---

aanmerking te neem deur te bevind dat daar nie 'n nou genoeg verband tussen die handeling en die uiteindelike gevolg, naamlik onbegrensde aanspreeklikheid, is nie. Dan sal sodanige skadeveroorsakende optrede steeds onregmatig wees, maar die dader se aanpreeklikheid sal binne redelike perke gehou word".

under the banner of legal causation because 'direct consequences' and foreseeability, which are typical legal causation considerations, were also taken into account. A third but unlikely possibility, says Potgieter, is that the court did not want to commit itself to either one of the two approaches but considered liability purely on the basis of public policy, irrespective of whether or not it could have been brought within one of the existing elements of delict[255]. Midgley[256] observes that the conduct and harm

---

255 Midgley JR considers *Mukheiber v Raath* in 'Principles of Liability in the Modern Law of Delict: Holy Cows or Horses for Courses?' 2000 *Acta Juridica* 79. He states that: "Although there are different ways in which the unlawfulness of an misrepresentation could be approached, common to all approaches, the court pointed out, is the fundamental principle that tortuous liability is found not upon the act performed by the defendant, but upon the consequences of that act: whether or not there was a violation of a right or a dereliction of a duty would depend on a number of considerations, including in the final instance, public policy. In the case at hand, the circumstances indicating that there was such a duty included the relationship between the parties; the material nature of the representation; the seriousness of the potential harm; and the fact that plaintiffs were laypeople. The doctor had not taken reasonable steps to avoid making the misrepresentation which meant that the misrepresentation was unlawful. [Midgley states in footnote 28 that this statement is unfortunate in that it might give the impressions that the failure to take reasonable steps in the circumstances (part of the negligence test) would render the conduct unlawful or that there had been an omission which was unlawful. A proper foundation would have been to say that there had been a misrepresentation in circumstances in which a duty rested upon the doctor not to make such representation. A failure to comply with that duty rendered the conduct unlawful] Whether there were any special considerations of public policy which would deny the plaintiffs their claim was dealt with when legal causation was considered. Regarding negligence the Court confirmed that the expected standard of conduct is that of the *bonus paterfamilias*: 'An act which falls short of this standard and which causes harm unlawfully is described as negligent; i.e. it is tainted with *culpa* [para 31 1077D]' It then formulated that test for *culpa* – an updated version of that enunciated in *Kruger v Coetzee* [1966 (2) SA 428 (A) as follows: 'For the purposes of liability, *culpa* arises if-

(a) a reasonable person in the position of the defendant –
  (i) would have foreseen the harm of the general kind that actually occurred;
  (ii) would have foreseen the general kind of causal sequence by which that harm occurred;
  (iii) would have taken steps to guard against it, and
(b) the defendant failed to take those steps'

Factual causation was not in issue. However on the question of limiting a defendant's liability for the factual consequences of his or her conduct the Court stated that there are two main schools of approach. 'Legal causation' cases indicated that public policy plays a role, even a decisive role, in limiting liability. Yet the Court noted, with the relative approach public policy plays the very same role in establishing which consequences of an act are to be regarded as wrongful, thus creating, and at the same time limiting, liability...The Court then considered the policy considerations noted in *Administrator, Natal v Edouard* a similar case in which the plaintiffs had succeeded in contract, and held that despite the claim before it being delictual, the duty of care in either case must be measured by the same yardstick: the same policy considerations that underlie the *Edouard* judgment were applicable in this instance. It found that the plaintiffs' reasons for wanting the operation were socially acceptable; there was no undue burden on doctors, while indeterminate liability posed some concerns regarding the maintenance claim but it was a 'direct consequence of the misrepresentation' and foreseeable and his liability would be no greater than that which rests on the parents. Public policy did not militate against holding the doctor liable." After briefly describing the facts and judgments in a number of other cases including that *of Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd* 2000 (1) SA 827 (CA), Midgley goes on to observe that when assessing negligence the focus appears to have shifted from the foreseeability and preventability formulation of the test to the actual standard to be applied – conduct associated with a reasonable person – with a 'salutary reminder' that what constitutes negligence 'ultimately depends upon a realistic and sensible approach to all the relevant facts and circumstances that bear on the matter at hand. He states that that *Kruger v Coetzee* test, or any modification thereof, has been relegated to a formula or guide which doe not require strict adherence. It is merely a method for determining the reasonable person standard. Midgley says that by adopting a flexible approach to the negligence issue the court has reconciled the opposing views regarding the fault criterion and its role in limiting liability in much the same way as it did regarding the test for legal causation, where the direct consequences and foreseeability tests were placed under the 'flexible criterion' umbrella. In future, courts need not concern themselves with which is the correct approach, an abstract or a relative one. As with causation, the principle is now one of 'horses for courses': the facts of the case will determine which approach is best suited to the circumstances. Midgley notes that a significant aspect for future reference is that the Supreme Court of Appeal has now articulated three formulations of the foreseeability and preventability test, which can be used as guidelines for determining the standard of the reasonable person: first the *Kruger v Coetzee* formulation as applied in *Groenewald v Groenewald* 1998 (2) SA 1106 (SCA), an entirely abstract approach in which the nature and manner of the harm need not be foreseeable and where legal causation is used to limit liability; second, the *Kruger v Coetzee* formulation as modified in *Mukheiber* and where the wrongfulness and fault elements are used for limitation purpose; and third, the *Sea Harvest* formulation in which *Kruger v Coetzee* is interpreted restrictively according to the relative approach but which also endorses the concept of legal causation. According to Midgley, although the need for flexibility was emphasized, this latter hybrid of the abstract and relative theories appears to be the favoured formulation – a triumph of pragmatism over principle.

On the subject of intention and legal causation Midgley notes: "Although intention has been a hot potato at times, it is settled that the concept consists of two aspects, the intention to achieve a particular consequence in the knowledge that one's conduct is unlawful. This means that little difficulty arises when imputing liability, for it is, in modern parlance,

only equitable, fair and just to hold one responsible for the consequences which one intended. However, in *Groenewald* [*supra*] the Court noted that a defendant would be at fault where there was intention to cause (some) harm, 'even if he did not intent that the consequences of such conduct would be to cause the kind of harm actually suffered by the plaintiff or harm of that general nature.' This statement appears to view the intention in the abstract, contrary to principle and, if accepted, would cause one to rethink whether or not it is true in all instances to say that intended consequences cannot be too remote. Take the following example: X punches Y on the chest. Y, who unbeknown to X has a weak heart, is highly traumatized by the incident and suffers a stroke. It is clear that X intended to cause Y harm but did not intend to cause the harm actually suffered, nor harm of that general nature, i.e. psychiatric injury. He did not intend the consequences that resulted so surely, in respect of the harm that resulted, there is no fault in the form of intention. If I am wrong in this view, then surely one's sense of fairness, equity and justice would lean in favour of no liability. In such a case intention cannot serve as a limiting criterion in the same way as it did in the past."

With regard to the relationship between wrongfulness and fault, Midgley points out that *Sea Harvest* made it clear that wrongfulness is distinct from the fault element; in *Cape Town Municipality v Bakkerud* 2000 (3) SA 1049 (SCA), the court following *Administrateur, Transvaal v van der Merwe* 1994 (4) SA 347 (A) 364G-H said that wrongfulness is the anterior question, with fault becoming relevant only after a situation is identified in which the law of delict requires action. In *Sea Harvest* and in *Mkhatswa v Minister of Defence* 2000 (1) SA 1004 (SCA) the opposite view was taken – that in the absence of negligence, wrongfulness does not arise. The view expressed in *Mukheiber* however, says Midgley, is that conduct which falls short of the standard set by the reasonable person *and* which causes harm unlawfully is negligent. Midgley states that at the heart of this conundrum lies a sense that one can be at fault only if one's conduct is unlawful: lawful behaviour cannot be termed 'negligent'. When courts look at the fault criterion, the element of wrongfulness has already been found to exist or is inherent in the type of conduct in question or has been presumed for the purposes of the negligence enquiry. However, in *Bakkerud*, the court said that a reasonable person should not be credited with a sense of ethical or moral responsibility and a propensity to act in accordance with such sense. One wonders, says Midgley if this statement is correct. Surely a reasonable person knows what is right or wrong and acts accordingly? Knowledge of the lawful nature of the conduct is implicit in a reasonable person's behaviour; and a reasonable person will not act unlawfully. Nonetheless, wrongfulness and negligence are separate enquiries and it appears that the comment was made in an attempt to show that the reasonable person test is inappropriate for determining wrongfulness, in the same way as public policy plays no role in determining whether harm was foreseeable. This is a different way of saying that wrongfulness considerations are inappropriate for determining negligence. In Midgley's opinion, a reasonable person obeys the law at all times, so wrongfulness must be anterior to negligence. He observes that part of the problem might be attributable to the different approaches to negligence. Viewed in the abstract, the focus is solely on the blameworthiness of the defendant's conduct, irrespective of the consequences, and one might be negligent even in circumstances in which one's conduct is not wrongful – the classic case of 'negligence in the air'. So it does not matter which issue comes first: they are unrelated to one another. Yet, with the relative approach, the negligence concept used both to limit liability and to determine fault and implicit in the second aspect of the enquiry is the existence of a legal duty and whether it has been breached. He notes that while this does not fully explain the view expressed in Sea Harvest and Mkhatswa, it might shed some light as to why unlawfulness creeps in under the negligence banner in *Mukheiber*.

With regard to the relationship between wrongfulness and legal causation Midgley notes that there is no doubt that the Supreme Court of Appeal favours legal causation as a means of limiting liability in most instances but while the relationship between the fault and causation elements now seems to be clarified the relationship between the wrongfulness and causation elements remains uncertain. He observes that when deciding wrongfulness the courts draw conclusions of law from the facts before them, so the statement in *Bakkerud* that courts make ad hoc decisions in such circumstances is neither novel nor extraordinary. Similarly when a decision regarding legal causation is made, it is an ad hoc conclusion of law based on particular facts. In both instances the decision is to grant or deny a remedy and takes the form of a value judgment based on a judicial perception of public policy. However, he says, it is important to bear in mind that in considering wrongfulness, a court determines whether the defendant is expected to behave in a manner which would not harm the plaintiff, whereas in legal causation the issue is whether or not the harm is too remote. Midgley notes that despite the apparently clear demarcation of boundaries between the wrongfulness and legal causation inquiries, these concepts and their roles have now become fuzzy. The reason he gives for this state of affairs it that legal causation is being used increasingly for purposes other than determining whether or not a factual causal connection is also legally relevant. To call it an inquiry into remoteness might soon be a misnomer for it has become a vehicle for deciding issues which traditionally fall within the domain of wrongfulness. While the direct consequences and foreseeability test focus clearly on the causal link between the conduct and the harm, the flexible criterion emphasizing reasonableness, fairness and justice which has not supplanted them, extends beyond mere matters of causation. He note that in Mukheiber the court apparently as party of an inquiry into legal causation, noted that the contractual and delictual duty of care should be measured by the same yardstick, which is very different form considering remoteness of harm. Although the court did enquire into the wrongfulness, it too, considered policy factors normally found in that inquiry – socially acceptable reasons for the operation; no indeterminate liability – as part of legal causation, together with the fact that the result was a direct consequence of the representation and foreseeable. He remarks that the court also used a phrase normally found in the wrongfulness enquiry: that there were no considerations of public policy which militate against liability. It seems, says Midgley, as if the wrongfulness element is no longer intended to play as important a role in judicial decision making as it did previously. In instances of positive physical conduct causing physical injury, including psychiatric injury, wrongfulness is presumed. The element serves as a means of fixing liability, with the focus shifting to fault and causation for determining the extent to which liability should be limited. In instances of wrongfulness involving statements and omissions, the wrongfulness element serves to determine whether or not the circumstances of the case dictated the existence of a legal duty to speak carefully or to act positively. Such decisions would involve policy considerations, like determining the legal convictions of the community in omission cases, which in turn involve the exercise of a judicial value judgment. The application of such policy focuses on the existence of legal duty, not on limiting liability. The latter aspect, which appeared to be integral to the wrongfulness inquiry a few years ago seems now to find its home in the legal causation inquiry and would include determining whether considerations of policy would militate against liability and would thus deny a claim or a remedy. Midgley says that there is no objection in principle to using both wrongfulness and legal causation to limit liability on the grounds of policy. But care should be taken to delineate the scope of each inquiry. Wrongfulness should focus on the extent of the duty or whether a right out

elements have not been affected by series of recent decisions involving the law of delict and neither was the concept of factual causation. He notes with regard to the latter that the *sine qua non* test prevails but it has long been accepted that common sense standards will be used where the but-for test is inadequate – and logic might even be discarded in some instances. Midgley observes that while the test in *Kruger v Coetzee*[257] is open to an abstract interpretation such as that applied by the court in *Groenewald v Groenewald* in terms of which one could be at fault even if a reasonable person would not have foreseen the causal sequence between the conduct and the harm, or the general nature of the harm which resulted, courts have tended to use a more focused approach, requiring that the general nature of the harm and the general manner in which it occurs must have been reasonably foreseeable. He says that the *Mukheiber* formulation reflects this development and in his view, is entirely accurate. Midgley states that it is a pity that the court backtracked from this approach in subsequent cases. He comments that the accumulative effect of the cases he discusses is that the test for negligence is now in some disarray. A similar uncertainty has been created regarding the wrongfulness and legal causation elements. It seems, he says, that the court is curtailing the once prominent use of the wrongfulness criterion to determine policy issues, hence the concomitant expansion of the legal causation element. Midgley highlights a further trend. In *Barnard v Santam Bpk* [258] the court found no need to set out general principles of liability and focused on the special features of the facts before it, yet in deciding the matter it resorted to established principles. The court in *Mukheiber*, he points out, also followed a principled approach, as did Streicher JA in *Sea Harvest*. On the other hand the majority in the latter case opted for flexibility, preferring the view that the courts should not rigidly adhere to formulae when resolving issues before them, a view supported in *Mkhatswa v Minister of Defence*[259]. He notes that *Bakkerud* completed the thought processes when it confirmed that when assessing wrongfulness the legal convictions of the community test is merely a means of reaching particular *ad hoc* value judgments. Midgley states that one can discern a clear view from these cases that the court does

---

to exist in the circumstances, while legal causation should be used to determine the quality of the causal link or the remoteness of the harm. In his view, issues of indeterminate liability and multiplicity of actions belong to the former enquiry not the latter.

256 Midgley JR fn 255 *supra*

257 *Kruger v Coetzee* 1966 (2) SA 428 (A)

258 *Barnard* 1999 (1) SA 202 (SCA)

259 *Mkhatshwa* fn 255 *supra*

not consider itself bound by established principles of law drawn from previous decisions. That collective wisdom might be useful and might direct the decision-making process to some extent; but the court will not allow principles to interfere with or to constrain what it believes to be just outcome for a particular case.

Midgley observes that some light on the trend to emphasize flexibility, reasonableness, fairness, justice and to focus on value judgments and policy decisions based on the facts of the case before the court is shed in recent article written by Nienaber JA[260]. Having canvassed opinions of a number of Supreme Court of Appeal judges, Nienaber JA compares the roles of judges and legal scholars in South African society and highlights their different approaches to issues of law. He notes that a judge's principle task is to resolve the dispute, not to synthesize the law and a judge's legal intuition as to the correct norm to be applied, based on an understanding of the facts, plays a decisive role in the decision-making process. A judge's legal conviction is geared towards the norm, which ought to produce the desired result, but is not a substitute for the appropriate legal rule. Yet, where judges collectively believe that a dispute should be resolved in a particular way, situations may arise where the only way in which to achieve that result is to amend the existing rule or to render it more flexible. According to Midgley, what appears to be happening in the cases under discussion is the finalization of a framework in terms of which Nienaber J's candid explanation of the judicial decision-making process can take effect. In all instances, a just resolution of the dispute between the parties is paramount and although principles of law are still relevant in reaching this objective, no single principle is to be regarded as a holy cow[261]. Flexibility is the keyword and the facts of a case will determine which method of reasoning suits the circumstance.

In his concluding remarks, Midgley states that while the cases have not jettisoned any of the established principles of liability, gone are the days when one could confidently assert that every element must be used to determine liability in particular cases. He notes that in Mukheiber it was said that every element must be used to determine

---

260 Nienaber PM 'Regters en Juriste' (2000) 1 *TSAR* 190

261 This sentiment is not new although it is fascinating to see it making a conscious comeback if Nienaber's research is correct and there is a calculated movement within the judiciary in this direction. A little over two thousand years ago a remarkable teacher once admonished the priest/lawyers of his time that: "The Sabbath was made for man; and not man for the Sabbath" (St Mark chapter 2 verse 27 *The Bible* (King James Version))

liability but the court was quite happy not to do so in *Barnard*. He says that the cases indicate that a value judgement as to what is fair and reasonable in the circumstances, based on a judicial assessment of current social policy has not become the overriding factor. He points out that it has always permeated the traditional elements of liability, particularly the wrongfulness and causation elements, but now we see all the standard criteria for liability being reformulated to place public policy - the notorious unruly horse – at the forefront. Midgley observes that judge Nienaber has also pointed out that a scholar's concern is the ordering and systematisation of law, that concepts and systems take precedence and the resolution of a factual dispute is often of less importance than the impact of a judgment on the legal system as a whole. To a judge, says Nienaber, this is also important but of secondary concern. Midgley says that although he does not wish to render the need for justice subservient to principles and concepts, and that the judgments under discussion correctly point out that principles are to serve as guides for achieving just results the principles remain important. They constitute a collective sense of what is just – the boni mores of society- and provide clarity, certainty and also flexibility to accommodate new situations. But as important: principles form the platform for organized thinking and guard against erratic decisions, fuzzy logic and intellectual laziness as well as any temptation for judges, consciously or subconsciously to follow a line of least resistance. They also, he says, provide certainty and allow society to regulate its affairs according to known legal standards. There will always be hard cases and it is to be accepted that conclusions may differ on occasions but such different conclusions, based on accepted principles instead of a judge's inherent feel for a case, will not necessarily render a decision unjust *inter partes* or otherwise. Midgley says he is also somewhat concerned about the role of the Supreme Court of Appeal in establishing norms and standards and in providing guidance. Society cannot afford to litigate every dispute to obtain an ad hoc decision on the facts and the practice of law should not become a lottery in which lawyers try to second guess a judge's judicial intuition. He states that society and lawyers in particular look to the Supreme Court of Appeal for intellectual leadership and to provide well-reasoned judgments setting out the law which can serve as leading cases for determining future disputes. Midgley concedes that some of the judgments under discussion do just that but there are also some concerns. He asks whether one should be content for example, with the statement in Groenewald that once can have intention if one intends some harm, even if one subjectively did not

foresee the actual consequences? Or when assessing negligence, with the clear contradiction in *Groenewald* on the one hand and *Mukheiber* and *Sea Harvest* on the other, as to whether or not a reasonable person would foresee the nature and cause of the harm? Does a reasonable person obey the law? Should we accept that it does not matter that the Supreme Court of Appeal gives mixed messages concerning which of the wrongfulness or negligence inquiries comes first, because that will be dependent upon the facts of the case? Or that the facts determine whether multiplicity of actions is a wrongfulness issue or one of causation? Or, he asks, should a judge be able to change conventional judicial wisdom as encapsulated in a principle, concept or formula, to suit the outcome which he or she desires? Should judges be able to disregard age-old principles, without any consideration of their rationale, on the basis that their ad hoc 'gut-feel' regarding the outcome of a particular dispute does not conform with established principle? Midgley observes that while such flexibility might give judges greater freedom to resolve disputes there is also greater scope for error, for which there is little accountability. The fact remains, he says, as judge Nienaber reocognizes that facts and legal principles are in the public domain, open to scrutiny but a judge's intuition remains un- articulated. Yet value judgments based on such intuition would never be wrong – for only the judge in the first instance can truly be said to have a full sense of the 'atmosphere' of the dispute. The value judgement could become a convenient disguise and there is a real danger that judges might become a law unto themselves. A judge's intuition, says Midgley, ought not to be the supreme law.

At the outset it must be stated that the writer is in total agreement with and echoes the concerns of Midgley as stated in the foregoing pages. It is respectfully submitted that in a flexible system such as the one apparently desired by the judiciary and which, according to Nienaber, it is currently working towards, a far greater degree of legal learning and analytical skill would be required of a judge than is the case under the present (should one say previous?) system of legal principle. Furthermore, although a system such as that postulated by judge Nienaber as being the nirvana of a number of members of the judiciary is in the mind of the writer technically, logically and legally conceivable[262] (without necessarily reducing litigation to the level of a lottery) it may

[262] An attempt is made at an outline of such a system in the pages that follow.

also require a capacity on the part of legal academics and the judiciary not only to analyse but also to synthesize to a greater degree legal concepts and principles. In short it would be a far more complex system than the one that is still largely in place. Obviously this is not an insuperable obstacle but in order to be successful in the long term such a system might well require an overhaul of the legal educational system not to mention the judiciary. On the other hand in the sort term it would be possible for such a system to accommodate the most narrow-minded and inflexible of judges who still insist on outdated and rigidly purist approaches to the application of law simply on the basis that such a system is sufficiently flexible to accommodate a wide variety of doctrinal approaches provided that there is suffient legal precedent to accommodate the alternative views. It would be the role of the legal scholars to identify the larger patterns of order emerging from the chaos at the lower level of the courts. In order to effectively do so, however, the former would need a complete set of mental tools that included the ability both to analyse and synthesize law.

It is submitted that the processes of synthesis and analysis are simply two opposite ends of a spectrum of mental processes that can be equally employed for the positive and beneficial development of law but that there has been a marked tendency in the past to employ only one end of this spectrum – and more extreme end at that – notably analytical thought, in considering legal principles and procedures. This tendency is in keeping with larger globally predominating trends emphasising the value of, and promoting and encouraging, human analytical thought almost to the total exclusion, in some fields of knowledge and learning, of other kinds of mental processes. It is a particular characteristic of the western world and is associated with the left side of the brain.

The arguments of Potgieter and Midgley, when contrasted, nicely illustrate this point and this is why they have been cited such detail. It is only in the detail that one gets a proper feel for the differences in their views which is somewhat ironic because, it is submitted, it is at the wider, systemic level that they differ most fundamentally. From a systems point of view, Potgieter is working squarely within a particular, well-defined and fairly narrow system of thought in arguing that the legal analysis in *Mukheiber* is logically unsound, regressive and therefore regrettable. His complaint in a nutshell, is that it does not follow the long established and well-recognised (for a

period of some ten years) rules or principles that have been developed within the law of delict with the result that one ends up with the (in his view) logical anomaly that the court is putting the cart before the horse in finding a person negligent before the unlawfulness of his actions has been established. Potgieter's analytical approach also reflects the manner in which doctoral theses in the legal field are written in South Africa, the manner in which their subject matter is chosen and the mode of much academic exegesis of the law in textbooks and legal journals[263]. It is located firmly at the analytical end of the spectrum where each statement is reduced to its most elemental and unitary form and then subjected to microscopic scrutiny. If it does not fit with the predefined framework which is usually long accepted and well established, then points of difference are highlighted and more often than not, rejected by the analyst as being unsound. Potgieter's approach allows for no deviation from the rules, the basic tools of the logical system with which he is dealing, or the manner of their application. Midgley, by contrast, is located much further along the spectrum of analysis-synthesis. Firstly, and significantly, he adopts a much broader view than does Potgieter. Apart from the fact that he considers in some detail six recent decisions by the Supreme Court of Appeal as to the two discussed by Potgieter, Midgley is prepared to entertain the possibility of systems within systems – in other words that the narrow system within which Potgieter operates in contained within a potentially wider, more comprehensive one that allows for legal development and evolution. For instance, when it comes to the detail, while Midgley does not disagree with Potgieter that when courts "look at the fault criterion, the element of wrongfulness has already been found to exist…", unlike Potgieter he acknowledges the possibility that both the relative approach to the question of limitation of liability and the legal causation approach are valid in certain contexts and that the difference between them is not such that it is irreconcilable. From a systems point of view, Midgley deliberately considers the relationship of each element in the logical system that comprises a delict to that of each other element, albeit in a somewhat linear fashion. His focus is as much on the content of the rules, the conceptual tools used by lawyers and courts alike, to ascertain whether there is delictual liability and if so, the extent of it, as on their application. Midgley is open to the possibility that there may be different ways to skin a cat and that there are few man-made systems whether in

263 The frequency with which the Russian dolls of microcosm within macrocosm manifest when one starts to look through a wide-angle lens instead of a microscope is intriguing to say the least.

the abstract or physical worlds, that cannot stand improvement. By contrast, Potgieter's focus, because it is too narrow to accept the possibility of the validity of different approaches, tends to be on the manner of the application of the rules, rather than the content and structure of the rules themselves and the complexities of their application which is why he comes up with a logical anomaly as a result. Although he does consider the relative approach, it is from a critical and unaccepting point of view. In his mind, its fate was decided before he put pen to paper. It has no valid existence in his 'world view' except as a means of demonstrating the correctness of his favoured approach to the limitation of liability - legal causation. A further example of this type of thinking, this time within the hallowed halls of academia in South Africa, is the unwillingness of some universities to recognise health law as a particular legal discipline or subject. The view is apparently that health law is no more than the sum of its parts, most notably the law of contract, delict, constitutional and administrative law, and that since these are already taught as subjects at these universities, a course in health law is unnecessary. This is a typically reductionist approach that maintains that the way to understand the whole is to understand its constituent parts. It is tantamount to saying that if one understands the atoms that go into the formation of a molecule of wood, one has everything necessary to comprehend the nature of a tree or a table. Midgley acknowledges that some of the elemental concepts in the law of delict have now become somewhat fuzzy and so is essentially not in disagreement with Potgieter on this particular point either. Midgley takes the view that 'there is no objection in principle to using both wrongfulness and legal causation to limit liability on the grounds of public policy but that care should be taken to delineate the scope of each inquiry' and he goes on to make some helpful suggestions as to how to do this. In total contrast to Potgieter, Midgley's approach recognizes the possibility of legal development, acknowledges the formulation of that legal development in *Mukheiber* and laments the fact that the court has backtracked from this approach in subsequent cases[264]. Midgley does not move so far down the analysis-synthesis spectrum that he is comfortable with the apparent view of the court that it does not consider itself bound by established principles of law drawn from previous decisions. As stated earlier, he

[264] At p 94–95 Midgley fn 255 *supra* states that: "In *Groenewald* the Court repeated established rules in respect of legal causation, but with regard to negligence, it interpreted the standard test in a manner different from previous interpretations. The Court held that one could be at fault even if a reasonable person would not have foreseen the causal sequence between the conduct and the harm, or the general nature of the harm which resulted. While the test in *Kruger v Coetzee* is open to such an 'abstract' interpretation, courts have tended to use a more focused approach, requiring that the manner in which it occurs must have been reasonably foreseeable. The *Mukheiber* formulation reflects this development and, in my view, is entirely accurate. It is a pity that the court backtracked from this approach in subsequent cases."

voices a number of very valid and grave concerns about the results of judge Nienaber's survey of the opinions of a number of Supreme Court of Appeal judges. Although there is scope in his 'world view' of the law for the concept that justice should not be subservient to principles and concepts he is extremely cautious about the manner in which the South African judiciary approaches this concept and the present writer respectfully concurs. There is the potential to plunge the legal system into chaos if this concept is not properly approached. It is with good reason that Midgley, at the start of his article states that the South African law of delict consists, not of a random, collection of miscellaneous, unrelated wrongs, but a set of principles, rules and concepts founded on historically-developed broad bases of liability, which provide elastic and adaptable principles for application in novel situations[265].

The obvious question is whether the "gut feel" approach the judges seem to favour can in any way be accommodated alongside the more traditionally accepted tools of legal exegesis. Is there a logical system that would avoid the evils validly feared by Midgley whilst at the same time accommodating the need for judges to be able to primarily 'resolve disputes'. It must, of course, be stated at the outset of this discussion that if anyone is likely to conceptualise these different elements of legal reasoning into a meaningful and internally consistent system, it will not be the judiciary. The writer begs the indulgence of those readers who are predominantly left-brained for the brief, somewhat metaphysical journey that follows.

It is submitted that, given the fact that judges will do what judges will do, it is up to legal scholars and academics to find other ways of systematizing the case-by-case approach. In the words of Baviaan - the dog-headed barking Baboon, who is 'Quite the Wisest Animal in All South Africa' in response to the question of Leopard as to where all the game had gone –

"The game has gone into other spots; and my advice to you…is to go into other spots as soon as you can."

---

265 In making the statement he refers to Van der Walt JC and Midgley JR, Delict, Principles and Cases vol 1 'Principles' (1997) para 18 and *Perlman v Zoutendyk* 1934 CPD 151 at p 155 as sources.

It is submitted that the game for present purposes is not the Zebra, the Eland and the 'Koodoo' featured in this Rudyard Kipling story[266] but rather the 'game' in the sense of a game that is played in accordance with a set of rules – in other words a system. What 'other spots' are available for legal scholars and academics to go to in order to get on top of the 'game'?

At the outset it must be stated that the proposal that follows as a method of accommodating alternate but equally valid systems of legal principle is premised on the validity and continued application of the principle of *stare decisis* in South African law and is not intended in any way to mean that this principle should be ignored by the courts or undermined. The principle of *stare decisis* has been acknowledged by both the constitutional court[267] and others[268] as being of critical importance to the development of the South African legal system and it is fervently hoped that the judges of the Supreme Court of Appeal in their pursuit of flexibility are not so zealous that they forget the finding of one of their number in the recent case of

---

266 Kipling R,'How the Leopard Got His Spots' *Just So Stories* 1902

267 Kriegler J in *Ex Parte Minister Of Safety and Security And Others: In Re S v Walters and Another* 2002 (4) SA 613 (CC): "The words are an abbreviation of a Latin maxim, stare decisis et non quieta movere, which means that one stands by decisions and does not disturb settled points. It is widely recognised in developed legal systems. 71 Hahlo and Kahn 72 describe this deference of the law for precedent as a manifestation of the general human tendency to have respect for experience. They explain why the doctrine of stare decisis is so important, saying: 'In the legal system the calls of justice are paramount. The maintenance of the certainty of the law and of equality before it, the satisfaction of legitimate expectations, entail a general duty of Judges to follow the legal rulings in previous judicial decisions. The individual litigant would feel himself unjustly treated if a past ruling applicable to his case were not followed where the material facts were the same. This authority given to past judgments is called the doctrine of precedent. It enables the citizen, if necessary with the aid of practising lawyers, to plan his private and professional activities with some degree of assurance as to their legal effects; it prevents the dislocation of rights, particularly contractual and proprietary ones, created in the belief of an existing rule of law; it cuts down the prospect of litigation; it keeps the weaker Judge along right and rational paths, drastically limiting the play allowed to partiality, caprice or prejudice, thereby not only securing justice in the instance but also retaining public confidence in the judicial machine through like being dealt with alike. . . . Certainty, predictability, reliability, equality, uniformity, convenience: these are the principal advantages to be gained by a legal system from the principle of stare decisis."
In *Mistry v Interim Medical and Dental Council of South Africa and Others* 1998 (4) SA 1127 (CC) the court stated that: "Whilst it may not be easy 'to avoid the influence of one's personal intellectual and moral preconceptions', this Court has from its very inception stressed the fact that 'the Constitution does not mean whatever we might wish it to mean'. Cases fall to be decided on a principled basis. Each case that is decided adds to the body of South African constitutional law, and establishes principles relevant to the decision of cases which may arise in the future." See also *National Director of Public Prosecutions and Another v Mohamed NO and Others* 2003 (4) SA 1 (CC); *Van Der Walt v Metcash Trading Ltd* 2002 (4) SA 317 (CC)

268 *Shabalala v Attorney-General, Transvaal, and Another Gumede and Others v Attorney-General, Transvaal* 1995 (1) SA 608 (T); *Wagener v Pharmacare Ltd; Cuttings v Pharmacare Ltd* 2003 (4) SA 285 (SCA). In *Ngxuza And Others v Permanent Secretary, Department Of Welfare, Eastern Cape, And Another* 2001 (2) SA 609 (E) Froneman J: "This principle lies at the heart of our system of legal precedent. Again, in MacCormick's words, at 75 - 6: 'hat I must treat like cases alike implies that I must decide today's case on grounds which I am willing to adopt for the decision of future similar cases, just as much as it implies that I must today have regard to my earlier decisions in past similar cases. . . . What is more, I should argue that its forward-looking requirement is yet more stringent than its backward-looking, just because - as we saw - there can genuinely be a conflict between the formal justice of following the precedent and the perceived substantive justice of today's case. That conflict cannot in the nature of the case arise when, unconstrained by unambiguous statute or directly binding precedent, I decide today's case in the knowledge that I must thereby commit myself to settling grounds for decision for today's and future similar cases. There is no conflict today, though there will be in the future if today I articulate grounds of decision which turn out to embody some substantive injustice or to be on other grounds inexpedient or undesirable. That is certainly a strong reason for being careful about how I decide today's case.'

Afrox Healthcare Bpk v Strydom[269] that the opinion of the court *a quo* that the principles of *stare decisis* as a general rule did not apply to the application of s 39(2) of the Constitution was, as far as post-constitutional decisions were concerned, clearly incorrect. It is submitted that the South African legal system is quite capable of development to the most satisfactory levels and standards without the sacrifice of this critical and central concept.

The tension in the South African law of delict between the theory and practice of law, as highlighted by Midgley, is not a purely South African phenomenon. Frankel in a paper written in 2001[270] notes in her introduction that

"Much has been written about theory and practice in the law, and the tension between practitioners and theorists. Judges do no cite theoretical articles often; they rarely 'apply' theories to particular cases." [271]

She notes that "theory, practice, experience and "gut" help us think, remember, decide and create. They complement each other like the two sides of the same coin: distinct but separable". Frankel observes that the dictionary definition of a theory includes words like "analysis", "speculation", "principle", "belief", "hypothesis", and

---

269 *Afrox Healthcare* 2002 (6) SA 21 (SCA). Brandt JA observed that: "Is die Hooggeregshof in hierdie geval by magte om uiting te gee aan sy oortuigings of is hy steeds deur die beginsels van stare decisis gebonde om die gemenereg toe te pas soos pre-konstitusioneel deur hierdie Hof neergelê? Die antwoord is dat die beginsels van stare decisis steeds geld en dat die Hooggeregshof nie deur art 39(2) gemagtig word om van die beslissings van hierdie Hof, hetsy pre- hetsy post-konstitusioneel, af te wyk nie. Artikel 39(2) moet saam- gelees word met art 173 van die Grondwet. Kragtens laasgenoemde artikel word erkenning verleen aan die inherente bevoegdheid van 'n Hooggeregshof om - saam met die Konstitusionele Hof en hierdie Hof - die gemenereg te ontwikkel. Dit is by die uitoefening van hierdie inherente bevoegdheid wat die bepalings van art 39(2) ter sprake kom. Voor die Grondwet het die Hooggeregshof uiteraard ook, netsoos hierdie Hof, die inherente bevoegdheid gehad om die gemenereg te ontwikkel. Hierdie inherente bevoegdheid was egter onderworpe aan die reëls wat in die leerstuk van stare decisis uitdrukking vind. Na my mening word hierdie reël nóg uitdruklik nóg by noodwendige implikasie deur die Grondwet verdring. Kortom, onderliggend aan die opdrag vervat in art 39(2), is die veronderstelling dat die betrokke Hof die bevoegdheid het om die gemenereg te wysig. Of die betrokke Hof inderdaad daardie bevoegdheid het, word onder meer deur die stare decisis-reël bepaal. Hierbenewens is die oorwegings wat die leerstuk van stare decisis ten grondslag lê steeds van toepassing, ook wat die pre-konstitutionele beslissing van hierdie Hof betref. Hierdie oorwegings blyk uit die volgende verklaring deur Hahlo en Kahn *The South African Legal System and its Background* op 214, wat ook met instemming aangehaal word deur Kriegler R in para [57] van die Walters-saak: 'The advantages of a principle of stare decisis are many. It enables the citizen, if necessary with the aid of practising lawyers, to plan his private and professional activities with some degree of assurance as to their legal effects; it prevents the dislocation of rights, particularly contractual and proprietary ones, created in the belief of an existing rule of law; it cuts down the prospect of litigation; it keeps the weaker Judge along right and rational paths, drastically limiting the play allowed to partiality, caprice or prejudice, thereby not only securing justice in the instance but also retaining public confidence in the judicial machine through like being dealt with alike... Certainty, predictability, reliability, equality, uniformity, convenience: these are the principal advantages to be gained by a legal system from the principle of stare decisis.'"

270 Frankel T, 'Of Theory and Practice' Boston University School of Law Working Paper Series, Public Law & Legal Theory Working Paper No 01-14 (http://www.bu.edu/law/faculty/papers)

271 She refers in footnote 1 to Honorable Williams SF 'Limits to Economics as Norms for Judicial Decisions' 21 *Harvard Journal of Law & Public Policy* 39 (1997) (arguing that economics is not descriptive and value neutral, and objecting to the use of economics as a guide to the law); Honorable Edwards HT 'The Growing Disjunction Between Legal Education and the Legal Profession' 91 *Michigan Law Review* 34, 35 (1992) ("(I see no reason why law professors should write mediocre economics, or philosophy, or literary criticism, when arts and sciences professors could be doing a better job) and as long as other law professors continue to do 'practical work"). For a description of the conflicts on the subject she refers to Sternlight JR 'Symbiotic Legal Theory and Legal Practice: Advocating a Common Sense Jurisprudence of Law and Practical Applications', 50 *University of Miami Law Review* 707 (1996)

"assumption". The thread that connects all of these words, she says, is *critical thinking and generalization – a general view of parts of the world.* The two components of theory are thinking in its various aspects and generalization – the recognition of observed or imagined patterns[272] covering numerous related details. She notes that the dictionary definition of practice includes "exercise", "custom", "habit", "repeat" and "perfect" and that the thread that connects all of these words is *repetition whether of acting or thinking*. Frankel observes that many of the words defining practice suggest acting on automatic pilot, so to speak, with no independent or critical thinking or attention. She sys that these words may denote acting or doing with little mindfulness or attention but that this is not, however, necessarily so. An artist practices the piano with great attention and concentration. The practice of the law and medicine in most cases is far from routine. Therefore, says Frankel, practice is not necessarily mindless, but it could be. She notes that practice produces experience, both for practitioners and for theorists. Experience is gained by repeated activities, including thinking. Practice is generally not mere repetition of identical actions, especially if the actions are complex, Each repeated action changes the actors and their product, adding to their experience, which refines their performance and enriches their memory.

---

272 R.C.L. 'Law and Disorder: The New Science of Chaos' observes that "the outer world can often seem as chaotic as our inner world – our stream of consciousness. Coherence can all too easily elude us... The fragmented, fractal nature of everyday reality, and people, is one of our basic problems. To use thinking to sort things out...we must first find the basic structure to reality. The structure reveals the order underneath the chaos." The writer goes on to discuss the hidden order in the physical world that has relatively recently come to light in terms of chaos theory and the mathematics of fractals which involves the study of logical systems with no immediately apparent order but in which there is nevertheless a distinct and recognizable pattern when viewed macroscopically. There is a very clear and, it is submitted, apposite analogy between fractals, such as the famous Mandelbrot set, which are ultimately the patterns of complex iterative systems, and the common law.
R.C.L. draws an analogy between the common law in effect in the US and in Britain, quotes Judge Aldisert as saying "The heart of the common law tradition is adjudication of specific cases" and states that for this reason, the common law is inherently flexible and changes with time and circumstance. The writer points to the statement of the American jurist Roscoe Pound that "Law must be stable, and yet it cannot stand still" stating that:" The common law flows from the facts of particular cases. From the cases come narrow rules of law, then slowly over time, broader principles of law are fashioned from the rules of many cases. In the often-quoted words of law professor, Munroe Smith in *Jurisprudence* (1909) "The rules and principles of case law have never been treated as final truths, but as working hypotheses, continually retested in those great laboratories of the law, the courts of justice. Every case is an experiment: and if the accepted rule which seems applicable yields a result which is felt to be unjust, the rule is reconsidered. It may not be modified at once, for to attempt to do justice in every single case would make the development and maintenance of general rules impossible; but if a rule continues to work injustice, it will eventually be reformulated. The principles themselves are continually retested; for if the rules derived from a principle do not work well, the principle itself must ultimately be re-examined." Common law is not etched in stone, it is continually created anew. In fact, above the entrance to Yale Law School is the engraving: "The law is a living growth, not a changeless code". The particular hornbook laws may vary and be modified as facts mold the law, demand exceptions or even the creation of new laws. The "Law" is a subtle, flexible thing which defies certainty and absolute predictions. AS the great jurist Cardoza put it in his essay, Growth of the Law (1924), 'When uniformities are sufficiently constant to be the subject of prediction with reasonable certainty, we say that law exists'. Cardoza recognised that certainty of prediction was never absolute, that in any one case, the rule of law could err. For Cardoza, as for today's modern physicist, Law is a matter of probabilities, not certainties." http://www.lawsofwisdom.com/LawsofWisdom/chapter6.html

It is submitted that what Frankel is saying in effect is that in real life, in chaotic systems, the patterns of thought that frame the concepts and conceptual elements of the system are iterative in the same way that fractals are iterative – that although the patterns of thought, for the purposes of the present discussion these would be represented by the legal rules and principles of the law of delict, are similarly or consistently applied, each iteration brings new perspectives and new insights into the pattern as a whole in ways that are not necessarily obvious. In fractals there is a vast difference between iteration and bland repetition. The blandly repetitive approach does not allow for change. It is not chaotic in the mathematical sense. It represents the more traditional rule that the rules themselves don't change although the contexts in which they operate do. In terms of complexity theory, which has some characteristics in common with chaos theory[273], the rules themselves can change but do so in terms of recognisable patterns that lend internal consistency to the system as a whole. It has been observed that although chaos and complexity are at times used interchangeably, they are not identical and need to be distinguished as their application to social systems may differ. Chaos theory or non-linear dynamics is based on the iteration either of a mathematical algorithm or a set of simple rules of interaction. It provides some powerful analogies associated with the edge of chaos, the emergence of order, and the co-existence of stability and instability[274]. However, complex social systems do not necessarily function through iteration, unless iteration is defined so broadly to accommodate cycles of learning and adaptation that it practically becomes meaningless. Chaos theory and complexity may share certain characteristics but differ in so far as a complex adaptive system is able to *evolve* and change[275].

---

273 Mitleton-Kelly E 'Organisations As Co-evolving Complex Adaptive Systems' http://bprc.warwick.ac.uk/eve.html She observes that "The notions of stability and instability provide another way of looking at complexity. This view is closely associated with chaos theory and sees complexity in terms of emergent order co-existing with disorder at the edge of chaos. When a system moves from a state of order towards increasing disorder, it goes through a transition phase called the edge of chaos. In that transition phase, new patterns of order emerge among the disorder and this gives rise to the paradox of order co-existing with disorder. Complexity in this view is seen in terms of the order which emerges from disorder"

274 S Mitleton-Kelly (fn 273 *supra*) states that: "Iteration was defined by Brain Goodwin [at an LSE Strategy & Complexity Seminar, on 23/4/97] as the "emergent order (which) arises through cycles of iteration in which a pattern of activity, defined by rules or regularities, is repeated over and over again, giving rise to coherent order." According to Mitleton-Kelly the distinction between chaos and complexity is particularly important when considering the application of the principles or characteristics of chaotic or complex systems to social systems. Her article starts from the viewpoint that social systems are fundamentally different from all other complex systems but she emphasises that this doe not mean that all the valuable work achieved by the sciences of complexity is disregarded. On the contrary, she says, such work needs to be studied as it can provide a significant starting point for the study of complex social systems. What must be *avoided* is the *mapping* of principles from the natural sciences onto social systems. Mitleton-Kelly points out that such an attempt would be inappropriate, as the subject matter of different disciplines is constituted in a different way and is based on different units of analysis (eg molecules, species, individual humans, societies, etc.). Mapping would also assume similarities between those systems studied by the natural and social sciences which may not exist, and which could lead to an ontological category mistake.

275 Mitleton-Kelly fn 273 *supra*

It is submitted that both chaos theory and complexity theory presents an extremely useful way of considering and organising the issues represented in the problems posed by Midgley, especially with regard to 'fuzziness', by the latest developments in the law of delict and the apparent approach of the judges of the Supreme Court of Appeal as presented by judge Nienaber[276]. Complexity theory suggests that in order to understand law as a complex system there should be a paradigm shift characterised in terms of a shift in the understanding of law from the:

---

276 Webb J in 'Why learning the law really is a complex business' http://www.ukcle.ac.uk/lili/2004/papers/webb.html points out that: " Complexity theory is a new way of looking at systems. It has emerged over the last 20 years or so (see Kauffman, 1990, 1992) from an almost primordial transdisciplinary soup of studies of self-organisation within genetic and other biological systems, and in parallel developments in the natural and (latterly) social sciences. These studied have encompassed fields as apparently diverse as cybernetics and artificial intelligence, quantum physics, the neurosciences, organisation management and economic and social theory. Even in law, a theory of legal autopoiesis has developed from the work, chiefly, of two German scholars, the sociologist Niklas Luhmann and the jurist Gunther Teubner. Since its emergence in the 1980s this has become an increasingly influential, but still primarily Euro-centric branch of legal theory, which draws heavily on concepts developed first in the study of living systems...The idea of a simple definition of complexity teeters on the brink of the oxymoronic, but most complexity theorists seem to agree that there are a number of relatively simple concepts fundamental to our understanding of complex systems. The particular formulation of complexity theory I intend to use today draws heavily, though not exhaustively, on work on neural networks and the so-called 'connectionist' principles derived from network theory. This isn't, as I have said, the only source of complexity theory but it is a branch which has obvious and strong links to issues of learning and cognition; it has been an important part of my own way-in to complexity theory and so I will use it primarily as my exemplar today...'Connectionism', 'neural networks' and 'parallel distributed processing' (PDP) are all names for a method of computation that attempts to model the neural processes of the human brain. Connectionism claims to be able to approximate the kind of spontaneous creative and somewhat unpredictable behaviour of human agents in a way that convention methods used by AI researchers relying on classical 'representational' theory, cannot. (Davis 1992; Churchland 1995). The classical model treats all cognitive processes as the result of an enormous number of syntactically driven operations –i.e. in simple terms, it treats 'intelligent behaviour' as a species of rule following. Connectionist models rely on the neurally inspired approach of PDP. A PDP network involves a collection of simply processing units (we can think of them as neurons) which are linked through a series of levels. The connections lines are critical, since it is they, not the neurons, which incorporate modifiable values (called weights) which determine the strength of the connection between neurons – this models the synaptic connections in the brain. The system functions by each neuron continuously calculating its input in parallel with all the others with patterns of activity developing depending on the modulating effect of the weights. Over time these patterns gradually relax into a stable pattern of activation in response to inputs received. The values of the weights are determined by a learning rule. In many experimental models, the rule is one called back-propagation – the system is put through a training phase in which it is presented with a set of inputs and a set of outputs, and the weights are adjusted through the intermediate levels of neurons. Through multiple iterations the system learns to generate the patterns which enables it to match the inputs to the outputs...What I am more interested in are the *systemic* features of neural networks, because it is at the systemic level that connectionism tells us some useful things about complexity more generally. Indeed it is tempting to see the developed neural network as a paradigm complex system. We can illustrate this by identifying those features of PDPs which appear increasingly to be treated by complexity theorists as generic features of complex systems:

1. 'Memory' or 'knowledge' does not reside in any single neuron, but only in the relationship between neurons – it is, in the jargon, *distributed.*
2. The network uses many essentially simply components which are richly interconnected and thus able to undertake quite complex activities (i.e. it is their *interconnectedness* or *relationality* that enables them to deal with complexity) (But this feature also limits both the comprehensibility of the system to any individual agent, and the ability to predict the influence that any individual agent has – cf the classical order at the edge of chaos arguments - Kauffman, 1990)
3. These interactions are in the form of complex patterns that are generated by the system itself – the system is to a degree, self-organising and its patterns are *emergency properties* of the interactions. This idea of emergence is of singular importance to complexity theory. Emergent properties are different from what we conventionally think of as properties: they are dynamic, often more than the sum of the parts (think about 'love' [and even more appositely, the present writer submits, 'justice'] as an emergent property! – it cannot be analysed by conventional means (though some of its manifestation can be), it does not readily yield to conventional causal explanation ...and often fundamentally unpredictable.
4. The relationality of complex systems also raises one other critical point for learning theory: the PDP research shows that learning in such systems is not rule-based in any explicit sense: the learning rule is merely a description of a relationship between inputs and outputs, it is not prescriptive in the representational sense. The model of the mind (and of language) can be approximately described by rules, but that is not the same thing; these rules are *post hoc* descriptions rather than true representations of how the mind works – the mind, this suggests, works in ways that are *relational* rather than representational, a notion which, if taken seriously could have significant implications for our understanding of things like the learning of associations."

- linear to the non-linear, recursive process;
- convergent to divergent;
- atomistic to the relational;
- uni-dimensional to the multi-dimensional; and
- intentional to the 'messy', random and unpredictable.[277]

Ontological modelling is another, related approach that could be useful to legal academics in systematising judicial pronouncements[278]. It has been stated that one of the main attractions of ontologies is their promise of simplicity and certainty in an ever more complex and ambiguous world[279]. The role of ontologies is to facilitate communication across different classificatory schema and in its most basic form ontology is an agreed upon concept of domain specific knowledge. Breuker and Winkels discuss the views and results related to the development of a core ontology that identifies the main concepts that are typical, and preferably exclusive for law. These are only a few, those related to normative knowledge (deontic terms) and to notions about legal responsibility. They observe that the vast majority of terms or concepts found in legal sources refers to *common sense*, albeit a special and often more restricted version of common sense knowledge. They point out that they can never represent all common sense knowledge, so must have to resort to foundational ontologies. According to Breuker and Winkles[280] an ontology describes how some domain is 'committed' to a particular view: not so much by the collection of the terms involved but in particular by the way these terms are structured and defined. This structure tells us "what a domain is about". It does not come as a surprise that for

---

277 See Webb fn 276 *supra* who makes these suggestions in relation to legal education. It is submitted that they are equally applicable to the law itself and the problems presently under discussion with regard to the latest developments in the law of delict.

278 Schafer, B, Vandenberge W and Kingston J in 'Ontological modelling and commitment to comparative legal theory. A case study' (www.juridicas.unam.mx/inst/evacad/eventos/2004/0902/mesa9/236s.pdf) observe that ontology based approaches have become increasingly widespread in the computer science community in general ad legal information systems design in particular. They state that: "Their importance has been recognized in fields as diverse as knowledge engineering, knowledge representation, qualitative modelling, language engineering, database design, object-oriented programming, information retrieval and agent based system design. Applications span from enterprise integration, natural language transition, medicine, e-commerce, geographical information systems and of course law.

279 Schafer *et al* fn 278 *supra*. They state that: "Global markets and the ubiquitous interconnectivity of systems and information processes in cyberspace that they bring with them have dramatically increased out awareness of the problems created by conceptual mismatches and failing system interoperability...The idea to agree on explicit and unambiguous subject taxonomies resonates particularly well with lawyers. Much of European Union legislation can be understood as the legal equivalent to ontology integration, most problems of private international law as partial responses to the problem of ontology mismatch where such higher level of agreement can be reached. Ontology based solutions have therefore unsurprisingly attracted the attention of lawyers working in multi-jurisdictional contexts. In the absence of supranational harmonization, these contexts are also particularly knowledge intensive, making the use of AI solutions even more plausible" [Note: AI in this article is an abbreviation for the term 'artificial intelligence].

280 Breuker JA and Winkels RGF 'Use and Reuse of Legal Ontologies in Knowledge Engineering and Information Management' (http://www.lri.jur.uva.nl/~winkels/LegOnt2003/Breuker.pdf)

instance, medical domains are about malfunctions. These malfunctions are often diseases, i.e. processes; they are classified in (multiple) taxonomies, and associated with sets of typical symptoms, and with treatments.

They explain that an ontology makes explicit the views one is committed to in modeling a domain. Modeling is taken here in the broad sense that includes the notion of understanding. A major and typical problem from jurisprudence (legal theory) occurs already in the use of the term "law".... Indeed, the problem of what counts as the unit of law is already one of the fundamental ones questions in jurisprudence and is called the individuation problem: "Classifying laws in logically distinct categories has always been one of the major tasks of legal philosophy...The classification of laws presupposes a solution to the more fundamental problem of the individuation of laws, i.e., an answer to the question 'What is to count as one complete law?"[281]

To come to the end of the metaphysical journey and apply (not map) the 'other spots' encountered to the law of delict, one must engage in the following mental exercise.

---

281 (Raz, 1972, page 825). Breuker and Winkels (fn 280 *supra*) note that: "There are two extreme views. The first one takes all legally valid statements in legal sources (legislation, precedence law, etc) as a whole: the law. The assumption is that in principle the individual statements in this whole are or should be coherently organized. This is the predominant view in jurisprudence and legal philosophy... Whether this coherence is an actual concern for the legal system (i.e., the law should be the object of proper knowledge management), or whether it is 'genetically' built-in by the constraints provided by fundamental, 'natural' legal principles, is a long and classical debate in legal theory. As [Van Der Velden, 1992] points out, the latter view takes the notion of coherence beyond what he sees as 'linguistic' or semantic coherence. It is this kind of coherence we are concerned with here. However, the other extreme takes all legally valid statements as being individual laws. *In extremo* this view is incorrect, if only because it presupposes some legally valid statement that covers the legal validity of an individual statement. This view is not a view that is shared with jurisprudence. Jurisprudence is in the first place concerned with justifying law, so legal scholars will not easily take validity statements in law as a side issue (see e.g. [Kelsen, 1991]). However, in legal knowledge engineering this alternative perspective is a far more fruitful one. The validity problem is presumed and the emphasis is on the coherent modeling of actual law. The coherence is not to be found in the collection of legal sources themselves but in the worlds (domains) where the statements in these sources refer to. These statements are normative statements about behaviour. They qualify some kinds of situations as disallowed. The collection of normative statements is not aimed at describing all possible situations in a domain, but only those that have normative relevance. What is possible is assumed to be known (or to be found out) by the agents to which the law is addressed. This means that the collection of individual statements about some legal domain does not provide a full description of the domain, neither that coherence is to be found in the legal statements. The coherence has to be found in modelling the possible behaviours in the domain by 'reconstructing' what is assumed by the legal statements." [Footnotes omitted]
They refer by way of example to the ontological views contained in the works of some of the major legal theorists and philosophers as follows: "The Hartian distinction between *primary* and *secondary rules* (norms) has become a quasistandard in legal theory. Hart's distinction, carefully detailed in his 'Concept of Law' [Hart, 1961], draws a line between a first level which refers to human behaviour and a second, meta-level of the first, which contains knowledge *about* primary norms. These secondary rules may belong to three types: (i) ***rules of adjudication***, that can be used to determine authoritatively whether a certain primary rule has been violated or not; (ii) ***rules of recognition*** which define, directly or indirectly, which rules are the valid ones, and can therefore be applied; (iii) ***rules of change***, which define how rules are to be made, removed or changed. These distinctions point out three functions of secondary norms: to provide support for solving conflicts (adjudication), to specify the limits of the legal system (recognition) and to specify how the legal system can change in time (change)...
Hohfeld's theory is considered a landmark in American jurisprudence [Hohfeld, 1919]. An interesting (and unusual) aspect of Hohfeld's theory is that rights and other positional concepts that represent ***legal relations*** are considered primitives. There are two groups of interrelated legal relations or positions. The first group is composed by ***right, duty, no-right, privilege*** and has a strong normative flavour. These concepts are closely related to Bentham's concept of right, obligation and liberty. The second group consists of *power, liability, disability Immunity*. These concepts are more closely related to legal competences and legal responsibilities."

Assume a simple system in which the law of delict is a Black Box from which a certain output called justice is required. There is no indication at this stage of how the output is derived but the system is capable of an output and moreover the desired one. If this were not so, the system would ultimately self-destruct since it serves no useful purpose. This is one step up from Midgley's fears of a lottery since there is an expected outcome which most people can identify and one which the Supreme Court of Appeal judges would be unable to deny is valuable and necessary output of the system. In fact, according to judge Nienaber, the output of justice is the reason on which they base their requirement of flexibility. Of course that outcome in itself is relatively difficult to define in concrete terms because justice is an abstract concept, but for the moment there is an identifiable outcome which will distinguish a bad or undesirable decision in terms of the law of delict, from a good, or desirable one. A legal system that does not serve the interests of justice is ultimately self-defeating. An objective for the system as a whole is thus set. Even within the flexible system desired by the Supreme Court of Appeal judges, it is submitted, however, that there is room for a further level of complexity. Assuming that within the Black Box, called the law of delict, there are one or more sets of conceptual elements that will yield the desirable result, each set (or system) of elements must be internally logically consistent in its own right. In other words one cannot 'mix up' the elements of one set with the elements of the other and achieve justice as an output. This is because the definition of one element, ultimately must influence the definitions of the other elements in the set in order for the system to be able to achieve the desired output. Although there is flexibility in the choice of sets, and even in the definition of an individual element within that set, if the desired outcome is to be achieved then certain basic rules apply. A yet further level of complexity is still possible without compromising the flexibility required by the judges of the Supreme Court of Appeal. This is the level at which the individual elements in the various conceptual sets within the Black Box represented by the law of delict interact with each other. Bearing in mind that they must all interact with each other to produce the desired result in order for the law of delict to be a valid and useful system of law, this implies some rules as to the manner in which they are interconnected or interact, without necessarily reducing the flexibility desired by the judges. These rules may well be dependent on the nature of the factual system that is 'fed into' the Black Box since, if the system is dynamic and adaptive, which it has already been argued, the common law is, then

there is the potential for these rules to vary depending upon the facts of each case. In a system such as the one described above, stability and instability, uncertainty and certainty operate side by side to achieve a desired result. The system is flexible yet contained since in law there is an outer limit to the number of factors that is considered the minimum necessary to achieve the desired result. If a judge chooses a particular element from a particular set in order to decide the case, then from a legal academic point of view, his legal analysis must be consistent with the 'rules' of that particular set within the system. For example, if the judge in deciding the limits of liability in a particular case seizes on legal causation as the element he wishes to use, then his reasoning must be consistent with the logical system (set of elements) in which that rule operates namely that unlawfulness should be decided before negligence. However, it may be argued that if the judge chooses the set of elements in which liability is limited by considerations of negligence and unlawfulness then he is not necessarily bound to resolve the issue of unlawfulness before determining negligence. Internal consistency is the key. It may even be that in certain circumstances it is internally consistent to use elements that are common to both sets in order to arrive at a conclusion.

If a judge imbues the conceptual tool fondly referred to as the 'reasonable man' with a knowledge of the law, and with s sense of ethical and moral responsibility sufficient to act in accordance therewith, then there is no need for that judge to enter into a discrete and independent consideration as to whether negligence can exist in the absence of unlawfulness. However, if for the purpose of clarity, the court chooses to narrow the 'reasonable man' conceptual tool so as to exclude the question of whether or not a 'reasonable man' would act in accordance with the law, then negligence and unlawfulness become two discrete concepts which that court must then deal with accordingly. Either way, there is no need for absolutes. Those who enter into heated debates about whether the reasonable man test should include the possibility that a reasonable man would act within the limits of the law or not are missing the point entirely. The reasonable man test is one tool in a toolbox of conceptual tools that is designed to achieve an outcome called justice. The manner in which one conceives of his particular 'reasonable man' simply determines the manner in which the remaining functions are taken up by the other conceptual tools in his toolbox. The conceptual tool that bears the description, "a reasonable man who acts in accordance with the

principles of law", has the capacity to perform an extra function that, in the toolbox containing the conceptual tool called "the reasonable man who does not have a tendency to act in accordance with the principles of law", will be performed by some other conceptual tool. This is because if the role of the tools within the toolbox, or the function of the toolbox in which they are contained, is such that it contains the minimum number of functions or factors necessary to achieve justice, then any number of actual formulations of these tools is likely to achieve the desired result. Obviously it is up to legal scholars and the judges between them to (a) identify those tools and the sets into which they fall and (b) to make sure that the toolboxes do contain the minimum necessary to ensure that the outcome of their application is justice. This is where the increased levels of legal knowledge and learning referred to earlier, may in practice be required. Obviously a judge working with a single toolbox would have a much simpler life than those judges who want the flexibility to be able to use many different toolboxes. However the risk for the judge who uses only one toolbox is that it may not have inside it all that is necessary to achieve justice out of every set of facts that comes before him. Assuming that he can identify what is lacking, and instead of simply making a bad decision which does not produce the desired result, i.e. justice, he attempts to find a way around this problem, he would then be faced with a choice of modifying some of his existing tools (which can sometimes be a difficult and somewhat artificial exercise) or he can add new tools to his toolbox. Such new tools will in all likelihood already have been developed by those judges using more than one toolbox to begin with since the sets of tools in each toolbox are different. It is the difference between the 'serial' and 'in parallel' approaches to legal development. The advantage of such judges over the judge who uses only one toolbox would be that not only are they already aware of the alternatives open to them, but they know how to use them and which toolbox is the most useful in various factual situations. If one toolbox turns out to be unsuitable to achieve the desired result on a particular set of facts, then they can switch to another one. A judge who uses only one toolbox is obviously unlikely to follow precedents in which other toolboxes have been used unless he wants himself to become a multi-toolbox judge but there is still room for the observation of precedent to the extent that there are other decisions in which his preferred set of conceptual tools have been applied.

For a legal scholar or a legal practitioner trying to predict the outcome of a particular case, such a system would require the application of all of the likely toolboxes to the facts of the case in order to see firstly whether the results of each test are the likely to be the same or whether they are likely to differ and if so, on what basis. Since there has to be a measure of internal consistency in the manner in which the individual toolboxes are applied to a particular legal problem there will still be a level of certainty. Similarly as time goes on and the problems themselves are categorized in terms of the system of precedent into those most conducive to resolution by a particular identified toolbox, yet more certainty will enter the system. In the case of the legal practitioner, the basis for the difference would give a good idea in which direction the legal argument before the court should be conducted in order to achieve a result most favourable to the client and in the case of the legal scholar i.e it would give a good idea of a possible direction of legal development, gaps in one toolbox in relation to another and how best to close them, and the most suitable applications of a particular toolbox to specific types of factual settings.

It is submitted that the value of the role and work of legal academics within a system of law in which chaos theory, complexity theory and ontology are valid and applicable conceptual tools is inescapable and inestimable. An approach to legal exegesis which includes the identification of the various possible elemental sets within various fields of law, the scope and manner of the interaction between the individual elements of those sets, the influence of one set upon another, the development of new sets and subsets, and the suitability of certain sets over others for the resolution of particular factual paradigms is a playground of cosmic proportions for legal scholars. The judges may have their flexibility and their gut feel. It is the legal academics to whom litigants will turn for an explanation of what just happened. In the process, it may be that the judges will get what they want too. The ability to play with the rules in such a way as to achieve that elusive but highly prized ideal of all rational societies – justice.

9.2.16 Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another[282]

[282] *Michael* 2001 (3) SA 1188 (SCA)

Facts

The plaintiffs' son, Minas ('the patient') sustained an injury to his nose in sports accident. He consulted a plastic and reconstructive surgeon, Dr Fayman, who recommended a rhinoplasty in order to remove a hump on the dorsal aspect of the nose and to correct a deviated septum. The operation was arranged for 10:00 on 7 December 1994 at the first defendant's clinic. Dr Fayman was assisted by Dr Rubin and the second defendant, a specialist in anaesthesiology, was the anaesthetist. All three doctors were in private practice. The first defendant's employees who were involved in the events of that morning were Sister Montgomery, the sister in general charge of anaesthetics and recovery, and Sister Glaeser who was the anaesthetic sister assigned to this particular operation. They were both registered nurses. A Lohmeier defibrillator was included in the clinic's emergency equipment on a resuscitation trolley. This was a portable electronic apparatus designed to restore normal rhythm to a fibrillating heart by way of electric shocks applied to the chest wall. It was Sister Glaeser's duty to make sure that this defibrillator was in working order and to use it when called upon by the second defendant to do so. As anaesthetist, he was in overall charge of all necessary resuscitation measures. At about 9:40 the pre-operative process started. The initial stages included the insertion into the patient's left hand of an intravenous tube connected to a drip-line and the attachment to his person of leads from items of equipment reflecting, blood pressure, heart rate and electrocardiographic (ECG) tracings of heart rhythm. Anaesthetic induction commenced at about 9:45 employing a combination of inhalants and intravenous drugs. Among the drugs administered intravenously was one milligram of propranolol hydrochloride (propranolol) given to prevent an untoward increase in heart rate during the operation. Propranolol is a beta blocker which lowers excessive heart rates by blocking the beta adrenergic receptors in the heart which govern heart rate stimulation. It is manufactured in tablet form and also in one milligram (one millilitre) ampoules for intravenous administration. In South Africa it is sold, inter alia, under the trade name 'Inderal'. The package insert published in November 1993 by the South African distributors of Inderal stated that intravenous administration was for the emergency treatment of cardiac dysrhythmias especially including supra-ventricular tachydysrhythmias. The recommended dose was one milligram injected over one

minute which could be repeated at two-minute intervals until a response was observed or to a maximum, in the case of anaesthetised patients, of five milligrams. At about 9:50, with the patient now fully generally anaesthetised, Dr Fayman injected a local anaesthetic (lignocaine and adrenaline) into the nose and inserted at the back of each nostril a plug of ribbon gauze soaked in a cocaine solution. The use of cocaine had a two-fold purpose. It is a local anaesthetic and a vasoconstrictor. The blood vessels of the nasal lining bleed very readily and it was necessary to constrict them to ensure a clear field for the surgeon. Cocaine is widely used for this purpose in ear, nose and throat surgery. The mass of cocaine in the solution was approximately 150 milligrams (being 1,76 milligrams per kilogram of the patient's weight, which was eighty-five kilograms). The limits of a safe dose are from 1,5 milligrams to 2 milligrams per kilogram. Because not all of the solution was in contact with the inner nasal surfaces only about eighty per cent of the cocaine would have been absorbed. Cocaine, either in overdose or in patient over-reaction, has cardio-toxic effects which can lead to cardiac arrest. One of these is its local anaesthetic effect, which impairs electrical conduction within the heart and diminishes the contractility of the myocardium - the heart muscle. Another is its propensity to result in coronary vasospasm which leads to myocardial ischemia. Cocaine toxicity exhibits a well-known pattern of heart reaction, first hypertension and tachycardia, then ventricular arrhythmias, then falling blood pressure and heart rate, then ventricular fibrillation and finally cardiac arrest. At 10:00 the operation began. This kind of operation usually took Dr Fayman about one hour and involved, after an incision in each nostril to enable lifting the soft tissue off the ridge of the nose, operating first in one nostril and then in the other. The surgery encompassed lowering the bony ridge to the desired degree by rasping it from both sides and then trimming the cartilaginous portion of the nose with a scalpel. Dr Fayman completed the rasping process on the left side and went on to operate on the right.

Between 10:15 and 10:28, while surgery was in progress, bleeding in the nose suddenly occurred in the right nostril which obscured the surgical field and brought the operation to a stop. With the bleeding there was a dramatic and alarming increase in the patient's heart rate and blood pressure. In the evidence this high level of heart rate (tachycardia) and high blood pressure (hypertension) was called 'the hypertensive crisis' and the tachycardia itself was identified as a supra-ventricular

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

tachydysrhythmia. The second defendant diagnosed too light anaesthesia as the cause of the crisis. This did not mean inadequate anaesthesia. The difference is that adequate anaesthesia can during surgery become too light by reason, not of reduction in anaesthetic, but of excessive surgical stimulus. He deepened the degree of anaesthesia, and to bring down the heart rate and blood pressure, which presented the risk of cerebral haemorrhage, he injected a further one milligram of propranolol into the drip-line. The heart rate and blood pressure came down as intended but thereafter they continued to decline. At below 60 beats per minute the heart rate became what is called bradycardia. Early in the bradycardia the ECG monitor displayed features of a normal tracing, including the characteristic peak and lows referred to as the QRS complex. This complex then soon broadened, indicating a symptomatic bradycardia. At about this time the second defendant instructed Dr Fayman to undertake cardio-pulmonary resuscitation (CPR) by way of external heart massage. The second defendant considered that there had been an over-action by the propranolol and to counter it he started administering, in conjunction with the CPR, a sequence of different drugs (ephedrine, isoprenaline and adrenaline) to try to raise the heart rate and blood pressure by removing the beta blockade. All these measures failed and the patient's heart went into cardiac arrest at 10:28. Shortly before the arrest the second defendant noted that the ECG tracing had become a flat line. In other words there was no discernible wave. This led him to conclude that the patient's heart was in a state known as asystole, in which there is no electrical activity in the heart at all. Because shocking by defibrillator damages an asystolic heart he considered he was confined in his resuscitation efforts to CPR and drug therapy, those being the only measures by which rhythm can be restored if the heart is in that state. When, after about four minutes, these efforts failed to yield any apparent result, the second defendant's options were to leave the patient for dead or to employ the defibrillator in the hope that if the heart was not in asystole but in ventricular fibrillation a heart beat could be restored by defibrillation. A fibrillating heart is one in which there are electrical impulses but no rhythm and no output. Its energy goes into rapid, random, uncoordinated contractions, all in complete disorder. What defibrillation does is to shock a fibrillating heart into momentary asystole and afford it the opportunity for a normal beat to resume spontaneously. The Lohmeier defibrillator ('the Lohmeier') was therefore brought into action. On the second defendant's instructions Sister Glaeser set the device to deliver a charge of 200 joules. When she did so she noticed that the

number of joules digitally displayed as reflecting the strength of the required charge did not stay at 200 but started decreasing while she was busy preparing to activate the defibrillator. She nevertheless proceeded to cause delivery of a shock. The patient's body responded but not his heart. For some minutes after that, CPR and adrenaline were repeated. A second shock at 200 joules was ordered. The outcome was the same. Again the number of joules on the display fell before the shock could be given. After renewed CPR and further adrenaline a third shock was ordered, this time at 360 joules. The heart remained in arrest. Once more the digital display decreased. Because Sister Glaeser and the second defendant thought that the diminishing display indicated that the apparatus was failing to hold its charge and was therefore defective, Sister Montgomery was sent to fetch another defibrillator. CPR and adrenaline were repeated. In addition, bretylium tosylate, sodium bicarbonate and calcium gluconate were injected into the drip-line.

From the intensive care unit Sister Montgomery returned in due course with another make of defibrillator. When programmed to deliver a charge of 360 joules, its digital display remained constant. With the new defibrillator a fourth and fifth shock were given. Both elicited a body reaction and, in addition, a heart beat. The fourth resulted in ventricular tachycardia and the fifth, sinus tachycardia - a fast but normal rhythm. By the time heart action was restored it was 10:44. Further resuscitation was required in the intensive care unit and so the operation was not completed. The nasal wounds were simply closed and the patient's nose was plugged and splinted. Prior to the cardiac arrest, and more or less contemporaneously, the second defendant recorded certain data regarding the operation. He used both sides of a stereotyped form which he himself designed and which he had had printed. One side was referred to as his 'chart'. His recordings were interrupted entirely by the arrest and resuscitation but later that morning he made further entries on the reverse side of the form under the heading 'Additional notes'. Later during the day he spoke to the plaintiffs and, in expressing his regret for what had happened, said of the operation that everything had been done correctly and that he did not know what had gone wrong.

During the afternoon the first defendant's general manager, Dr Malkin, spoke to Sister Glaeser. In recounting the morning's events, she indicated that in comparison with the second defibrillator the Lohmeier had seemed to be defective. In consequence Dr

Malkin wrote to the suppliers of the Lohmeier alleging that the resuscitation had failed because the defibrillator was unable to maintain the required charge and expressing concern that there had been a delay in the resuscitation. This prompted a number of independent tests of the apparatus concerned during the following year, the result of all of which was that it was reported to be in working order. It was also established that in all defibrillators the programmed charge diminishes between the time it is set and the delivery of a shock. This is due to electrical resistance within the apparatus. Lohmeiers constitute the only make whose digital display reflects that reduction and Sister Glaeser and the second defendant did not know this. At 19:00 on the day of the operation the patient was examined by a cardiologist, Dr J L Salitan, who performed an echocardiogram. He later reported that the patient's heart was enlarged and its left ventricular contractility significantly reduced. His conclusion was that there was 'marked global myocardial dysfunction, probably acute', possibly the result of prolonged hypoxia. Obviously prolonged hypoxia did occur and although it is in dispute precisely by what mechanism the myocardial damage came to be caused, what is not in issue is that hypoxia caused injury to the brain. Brain injury was sustained after the heart went into cardiac arrest and was ongoing for as long as the resuscitation period advanced without restoration of a heartbeat.

As regards the first defendant it was alleged that it failed to have a functional defibrillator immediately available when required alternatively, if the Lohmeier was functional, first defendant failed (at a time prior to the date in question) to inform Sister Glaeser about, and to train her in, the workings and manner of operation of the Lohmeier, thereby causing delay in the resuscitation process when the Lohmeier appeared to her to be defective and to require replacement by a substitute defibrillator.

As regards the second defendant it was alleged in relation to the cardiac arrest that:

1. He failed to take adequate account of the effect which the cocaine would have in conjunction with what he himself administered and to guide Dr Fayman as to the upper dose limits of cocaine.
2. He failed to dilute the propranolol which was given to combat the hypertensive crisis or to administer it in doses of between 100 micrograms and 500 micrograms at a time.

3. The use of propranolol in conjunction with cocaine created the risk of sudden heart failure.
4. He failed to recognise the risk of, or to prevent, life-threatening bradycardia and cardiac arrest.

In relation to the resuscitation it was alleged that:

5. He failed to ensure beforehand that a functional defibrillator was available and that he was reasonably acquainted with its workings. This caused a delay in the resuscitation process when a second defibrillator was sent for.
6. When the patient's heart was in fibrillation he failed to order defibrillation at the earliest opportunity. Alternatively, he attempted defibrillation on an asystolic heart thereby worsening the outcome. In the further alternative he failed to deliver three quick shocks in a 'stacked sequence' in accordance with certain published algorithms approved for emergency cardiac resuscitation.

Judgment

The court had to decide what was the cause of the cardiac arrest. The plaintiffs contended that it was propranolol and that the hypertensive crisis was occasioned by too light anaesthesia. For the second defendant it was maintained that the cause of both the hypertensive crisis and the arrest was cocaine toxicity. The question was whether the arrest was foreseeable as a reasonable possibility, meaning a possibility which a reasonable anaesthetist would foresee and guard against. If the cause of the arrest was cocaine toxicity and the arrest was indeed foreseeable in that sense, the question would then be whether the arrest was reasonably avoidable. The main subsidiary question allied to the first issue concerned the length of time between the hypertensive crisis and the cardiac arrest and that, in turn, depended on the credibility and reliability of the witnesses who were centrally involved in the operating theatre at the time. For the plaintiffs they were Doctor Fayman, Doctor Rubin and Sister Glaeser. On the opposite side, the second defendant stood alone. Other subsidiary questions were whether, irrespective of the cause of the arrest and irrespective of the correctness of his conclusions, the second defendant was reasonable in diagnosing too light anaesthesia as the cause of the hypertensive crisis and in giving propranolol as the counter and whether he was at fault in relation to either the size of the dose or the

manner of its administration and whether it was reasonable to diagnose a propranolol over-action as the cause of the bradycardia.

The second essential issue is whether the Lohmeier defibrillator was defective and, if not, whether the ignorance of the second defendant and Sister Glaeser as to the manner of its workings was culpable and whether their ignorance occasioned an unreasonable delay in the resuscitative process. Allied questions were whether the heart arrested in asystole or fibrillation; when fibrillation occurred if initially there was asystole; whether fibrillation was immediately amenable to defibrillation and, if not, when it first became amenable. Finally, on the matter of delay, the crucial enquiry is whether the fourth shock (and the fifth if required) would have been given materially earlier had the Lohmeier been in proper working order and had Sister Glaeser and the second defendant known that. The court held that the answer to that enquiry entailed examination of what resuscitation measures were in progress between the third and fourth shocks and whether the picture would have been different in the absence of their ignorance.

The Supreme Court of Appeal noted in its judgment that in the trial court, none of the experts was asked, or purported to express a collective or representative view of, what was or was not accepted as reasonable in South African specialist anaesthetist practice in 1994. It stated that although it has often been said in South African cases that the governing test for professional negligence is the standard of conduct of the reasonable practitioner in the particular professional field, that criterion is not always itself a helpful guide to finding the answer. The present case, it said, showed why. Apart from the absence of evidence of what practice prevailed it was not a question of simply the standard, for example of the reasonable attorney or advocate, where the court would be able to decide for itself what was reasonable conduct. The court asked how the conduct and views of the notional reasonable anaesthetist could be established without a collective or representative opinion especially in view of the fact that the primary function of the experts called was to teach, with the opportunity only for part-time practice. In these circumstances, said the court, counsel were probably left with little option but to elicit individual views of what the respective witnesses considered reasonable.

The court said that what is required in the evaluation of such evidence is to determine whether and to what extent the expert opinions advanced in Michael's case were founded on logical reasoning. It referred with approval to *Bolitho v City and Hackney Health Authority*[283] and the dicta of Lord Browne-Wilkinson summarising them as follows:

> The Court is not bound to absolve a defendant from liability for allegedly negligent medical treatment or diagnosis just because evidence of expert opinion, albeit genuinely held, is that the treatment or diagnosis in issue accorded with sound medical practice. The Court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and has reached 'a defensible conclusion'
>
> If a body of professional opinion overlooks an obvious risk which could have been guarded against it will not be reasonable, even if almost universally held

The defendant, said the court, can properly be held liable, despite the support of a body of professional opinion sanctioning the conduct in issue, if that body of opinion is not capable of withstanding logical analysis and is therefore not reasonable. However, it will very seldom be right to conclude that views genuinely held by a competent expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which the court would not normally be able to make without expert evidence and it would be wrong to decide a case by simple preference where there are conflicting views on either side, both capable of logical support. Only where expert opinion cannot be logically supported at all will it fail to provide 'the benchmark by reference to which the defendant's conduct falls to be assessed'.

After analysing the evidence, the court held that much as the plaintiffs deserved the sympathy of all for the awful fate that had befallen their son and the profound grief this must have caused them, the trial judge was right to dismiss the claim. It held that the appeal could not succeed.

Discussion

283 *Bolitho* [1998] AC 232 (HL)

Carstens discusses this case in some detail[284]. He points out that it should be noted that the court emphasised the fact that in this case none of the experts was asked, or purported to express, a collective or representative view of what was or was not accepted as reasonable in South African specialist anaesthetist practice in 1994. The court evaluated the standard to establish the conduct and views of the notional reasonable anaesthetist without a collective or representative opinion. The court observed that the difficulty of determining this standard was exacerbated by the fact that the primary function of the experts who testified was to teach with only limited opportunity for part time practice, leaving counsel with little option but to elicit individual views of what the respective expert witnesses considered to be reasonable. He observes that in setting a standard to be applied to the expert evidence, the court relied on the decision of the House of Lords in the medical negligence case of *Bolitho v City and Hackney Health Authority*[285] in which it was held that a court is not bound to absolve a defendant from legal liability for allegedly negligent medical treatment or diagnosis just because evidence of an expert opinion, albeit genuinely held, is that the treatment or diagnosis in issue accorded with sound medical practice. The court must be satisfied that such opinion has a logical basis, in other words that the expert has considered comparative risks and benefits and has reached a 'defensible conclusion'. Carstens also observes that the court highlighted the essential difference between the

---

284 Carstens P 'Setting the Boundaries for Expert Evidence In Support Or Defence of Medical Negligence: Michael v Linksfield Park Clinic (Pty) Ltd 2001 (3) SA 1188 (SCA)' 2002 *THRHR* p430. He neatly summarises the approach to expert evidence in followed by the Supreme Court of Appeal in this case as follows:

- In delictual claims the issue of reasonableness or negligence of a defendant's conduct is one for the court itself to determine on the basis of the various and often conflicting expert opinions presented;
- As a rule, that determination will not involve considerations of credibility but rather the examination of the opinions and the analysis of their essential reasoning, preparatory to the court reaching its own conclusion on the issues raised;
- In the case of professional negligence, the governing test is the standard of conduct of the reasonable practitioner in the particular professional field, but that criterion is not always a helpful guide to finding the answer;
- What is required in the evaluation of expert evidence bearing on the conduct of such persons is to determine whether and to what extent the opinions advanced are founded on logical reasoning
- The court is not bound to absolve a defendant from liability for allegedly negligent professional conduct (such as medical treatment or diagnosis just because evidence of expert opinion, albeit genuinely held, is that the conduct in issue accorded with sound practice
- The court must be satisfied that such opinion had a logical basis, in other words, that the expert has considered comparative risks and benefits and has reached a defensible conclusion. If a body of professional opinion overlooks an obvious risk which could have been guarded against, it will not be reasonable, even if almost universally held
- A defendant can be held liable despite the support of a body of professional opinion sanctioning the conduct in issue if that body of opinion is not capable of withstanding logical analysis and is therefore not reasonable. However, it will very seldom be correct to conclude that views genuinely held by a competent expert are unreasonable
- The assessment of medical risks and benefits is a matter of clinical judgment which the court would not normally be able to make without expert evidence, and it would be wrong to decide a case by simple preference where there ate conflicting views on either side, both capable of logical support
- Only where expert opinion cannot be logically supported at will it fail to provide the benchmark by reference to which the defendant's conduct fails to be assessed

Finally it must be borne in mind that expert scientific witnesses tent to assess likelihood in terms of scientific certainty and not in terms of where the balance of probabilities lies on a review of the whole of the evidence.

285 *Bolitho* fn 283 *supra*

scientific and judicial measure of proof with reliance on another decision of the House of Lords in the Scottish case of *Dingley v The Chief Constable, Strathclyde Police*[286].

In his comments on the case, Carstens points out that in essence the court in this case affirmed the general applicable principles already enunciated in the cases of *Van Wyk v Lewis*, *Webb v Isaac*, *Coppen v Impey*, *Pringle v Administrator Transvaal* and *Castell v de Greef* that the proof of medical negligence has to be determined with reference to expert evidence of members of the medical profession but that such determination in the final instance is for the court who is not bound to adopt the opinion of such testimony. He finds the analysis of the nature of the expert evidence in relation to the test for medical negligence problematic in the sense that the context in which it is applied by the court is 'somewhat clouded'. Carstens submits that this also rings true with regard to the court's assessment of conflicting schools of thought in medical practice. He says that the court correctly ruled that it must be satisfied that the tendered medical opinion must have a logical basis, in other words that the expert has considered comparative risks and benefits and has reached a defensible conclusion. However, the court added the rider to this ruling that a defendant can be held liable if the supporting body of expert opinion is not capable of withstanding *logical analysis* and is therefore *not reasonable*. Carstens submits that this statement whereby logic is indicative of reasonableness (conversely the absence of logic is indicative of unreasonableness) is problematic. He notes that it is conceivable that expert medical opinion based on logic is not necessarily indicative of reasonableness or unreasonableness within the realm of accepted medical practice. Logic refers to a process of reasoning/rationality based on scientific or deductive cause and effect. Therefore a given result or inference is either logical or illogical. Reasonableness on the other hand, says Carstens, is a value judgment indicative of or based on an accepted or standard norm. While it is true that logic more often than not is an integral part of reasonableness, it does not necessarily follow that logic can be equated to reasonableness. The distinction is illustrated with reference to the concepts of 'medical misadventure' and 'professional errors of judgment' within medical practice, where even 'illogical' medical mishaps/errors of judgment have been held to be

286 *Dingley* 200 SC 77 (HL) where it was said that: "One cannot entirely discount the risk that by immersing himself in every detail and by looking deeply into the minds of the experts, a judge may be seduced into a position where he applies to the expert evidence the standards which the expert himself will apply to the question whether a particular thesis has been proved or disproved...instead of assessing as a judge must do, where the balance of probabilities lies on a review of the whole of the evidence."

reasonable in terms of accepted medical practice. Carstens notes that it should also be emphasized that medical negligence should not be determined 'in the air' but with regard to the particular circumstances of each case. It is also highly improbable that any party to a medical negligence action would call an expert medical witness whose opinion is based on an illogical foundation – hence the ruling by the court that it will seldom be correct to conclude that views genuinely held by a competent expert are reasonable. He submits that the true test for expert medical opinion in medical negligence actions, is that the opinion should objectively and clinically reflect the standard or norms of accepted medical practice in the particular circumstances; that is to say whether the plaintiff's claim can succeed with reference to the standard of the reasonable competent anaesthetist in the same circumstances, alternatively whether the defendant-anaesthetist's actions or omissions are defensible with reference to the same yardstick. Carstens states that in the event of conflicting expert opinion or different schools of thought in medical practice, it appears that even a conflicting and minority school of thought or opinion will be acceptable, provided that such opinion accords with what is considered to be reasonable by that branch of the medical profession. He points out that the court's concern that it would be wrong to decide a case by simply preference where there are conflicting views on either side, both being capable of logical support could be overcome by strictly applying the ordinary rules of evidence. If both conflicting views on either side are capable of logical support (or rather are indicative of accepted or reasonable medical practice) the question arises whether the plaintiff has proven his or her case against the defendant medical practitioner on a preponderance of probabilities. The judgment then depends on the credibility and reliability of expert witnesses. If the scales are evenly tipped on a review of the whole of the evidence, then absolution from the instance should be ordered.

Carstens notes that although counsel referred the court to a plethora of relevant South African case law, in its judgment it referred to two judgments of the House of Lords, omitting any reference to or discussion of relevant South African case law. He states that this omission is regrettable as the Supreme Court of Appeal had the opportunity to extensively review leading cases on medical negligence in which the approach to expert medical evidence was paramount. He observes that it is not often that cases on medical negligence serve before the Supreme Court of Appeal and although principles

pertaining to the approach to expert medical evidence have generally been reaffirmed, it is specifically the approach to conflicting opinions representing different but acceptable schools of thought in medical practice that still remains open-ended.

It is submitted that the paucity of reference to South Africa legal precedent is further evidence of the trend identified by judge Nienaber as referred to in the article by Midgley discussed earlier in the section on *Mukheiber*. There is presently a disturbing lack of legal scholarship, or, to put it differently, a disturbing unwillingness to engage with the law on a more than superficial level, within South African courts and the Supreme Court of Appeal in particular that does not further the spirit or the letter of the Constitution requiring the development of the common law. It is further submitted that the attitude of the judges of the Supreme Court of Appeal surveyed by judge Nienaber that their main role is to resolve disputes is indicative of a narrow, unproductive and miserly approach to law in a country

- in which litigation is so expensive that it is more often than not inaccessible to the ordinary person;
- with a long history of human rights abuse that was sanctioned and condoned by the previous legal system; and
- which is only ten years into the development of a constitutionally based system of law and government that represents a radical departure from the system previously in place.

One might expect such an attitude from a judiciary operating in an environment in which the legal system was well developed, well established and in which there was no great need for judges to fulfil a leadership role in implementing the principles and values of a relatively new legal order. It is more than a little disheartening to see the quality and standard of some of the judgments that emanate from both the High Court and the Supreme Court of Appeal. Even more disturbing is the apparently increasing difficulty in obtaining the written judgments of the High Court within reasonable time periods and the fact that many judges mark judgments that they have given on issues of constitutional importance as unreportable[287]. In this context it is highly unlikely that

---

287 Botha J for instance, of his judgment in the case of the *Treatment Action Campaign and Others v Minister of Health and Others* in the Pretoria High Court were it not for the significant degree of public interest in the case and the fact that the Treatment Action Campaign is sufficiently well funded to have its own website upon which it can itself publicise judgments like this such judgments would not be generally or easily accessible to the public. Another case that was not reported is the decision of the Transvaal High Court in *Harris v Minister of Education*, another judgment that involved

a more complicated approaches to legal analysis will be adopted by South African courts and the exercise conducted in the discussion under *Mukhheiber* is likely to be little more than "pie in the sky". Instead it seems that one may be faced with body of decisions that are increasingly internally inconsistent to the point where there is no cohesive or higher vision present in South African case law. The decision of the court *a quo* in the case of *VRM* below is a good example.

9.2.17 VRM v The Health Professions Council of South Africa and Others[288]

Facts

The facts as they appear from the plaintiff's heads of argument are as follows:

The plaintiff, VRM, lodged with the first defendant, the Health Professions Council of South Africa, a complaint of improper or disgraceful conduct on the part of the third defendant, a Dr Labuschagne. The first defendant ruled that there has not been conduct on behalf of the third defendant which could be said to have been improper or disgraceful and resolved that no further action should be taken. The plaintiff sought the review and setting aside of this decision.

On 29 January 1999 VRM, consulted Dr Labuschagne. She was 6 month's pregnancy and wanted him to deliver her baby. He examined her to see whether she and the unborn baby were healthy and he took a blood sample. He did not inform her of the purpose of the test or that the blood was to be tested to determine the applicant's HIV status. In his response to her complaint, Dr Labuschagne stated that he had 'informed' VRM that the routine blood tests would include a test for HIV. There was no prior counselling before the test was taken. At the time of the consultation, although Dr Labuschagne informed VRM that 'routine blood tests' would be conducted he did not obtain her informed consent in terms of the guidelines on "The management of patients with HIV infection or AIDS" (the guidelines) which were in place since 1992 and which bind all doctors and other health professionals. The guidelines are explicit.

---

principles of constitutional law and which was upheld by the constitutional court in *Minister Of Education v Harris* 2001 (4) SA 1297 (CC).

288 As yet unreported. Case No 26129/2001 heard in the Transvaal Provincial Division of the High Court of South Africa Date 27 May 2002.

They state *inter alia* that:

2.4.1 Although infection with HIV and of Aids is incurable at present, Aids is considered a manageable life-threatening disease.

2.4.2 …Routine or universal testing of patients in the healthcare setting is unjustifiable and undesirable.

2.4.3 A good patient-doctor relationship and mutual trust are essential pre-requisites for the implementation of reasonable and equitable guidelines that will ensure that the requirement both of healthcare workers and patients are satisfied.

2.4.4 It is accepted that a healthcare worker will examine or treat a patient only with the informed consent of the patient. Similarly, taking a blood sample to test for HIV antibodies should be done only with the consent of the patient, in accordance with the guidelines set out below.

2.4.5 The requirements for informed consent are stated as follows:

Informed Consent

A patient should be tested for HIV infection only if he gives informed consent. Such informed consent should incorporate the following minimum standards:

If posters are displayed in an attempt to inform patients that testing for HIV may be undertaken, these must be supplemented by a verbal discussion between the doctor and the patient in order to appropriately obtain the patient's informed consent.

The patient should clearly understand what the purpose of the laboratory test is; what advantages or disadvantages testing may hold for him as patient; why the surgeon or physician wants this information; what influence the results of such a test will have on his treatment; and how his medical protocol will be altered by this information. The psychosocial impact of a positive test result should also be addressed.

The principle of informed consent entails that the healthcare worker accepts that if the patient were HIV positive, appropriate counselling will follow. The

healthcare worker must therefore ensure that the patient is directed to appropriate facilities that will oversee his further care and, if possible, counsel his family and/or sexual partners. The healthcare worker clearly also ethically has the right to inform identifiable sexual partners of the HIV positive status of a patient.

2.4.6 The results of HIV positive patients should be treated at the highest possible level of confidentiality".

During March 1999 VRM received an account from a pathology laboratory which mentioned 'HIV Elisa'. At s subsequent consultation with Dr Labuschagne, VRM and her husband enquired of Dr Labuschagne whether this reference had anything to do with AIDS. Dr Labuschagne told VRM and her husband that the account and its contents had nothing to do with AIDS and that the reason for the medical aid being charged with such test was a mistake. On 01 April 1999 VRM was admitted to hospital with labour pains. On 03 April Dr Labuschagne delivered the baby by caesarean section. It was stillborn. On 04 April Dr Labuschagne attended on VRM at the hospital and without preamble informed her that she was HIV positive. Dr Labuschagne issued a death certificate for the baby which records the cause of death as "stillborn", "HIV+". Dr Labuschagne advised VRM's husband of her HIV status. VRM's husband subsequently tested negative for HIV. At no stage did VRM receive any counselling as required by the guidelines from Dr Labuschagne or anyone else. On 9 July 1999 VRM, through her attorneys, lodged a complaint of professional misconduct against Dr Labuschagne and requiring the HPCSA to immediately start investigations into his unethical and illegal conduct.

On 4 October 1999 the first respondent, the HPCSA, resolved to make available to VRM Dr Labuschagne's explanation, contained in a letter to the HPCSA dated 27 August 1999. The gist of his reply as summarised by the appeal court came to the following:

(a) That he asked and obtained her consent to take a blood sample and to have it tested also to determine her HIV status.

(b) That he was aware thereof that she was HIV positive when her husband and she enquired, during March 1999, about the meaning of "HIV Elisa" but that as she was one month away from delivery he thought it in her best interests, from a psychological point of view, not to inform her of her status then. He states that he attempted "to sidestep" the question by explaining to them in medical terms that "HIV Elisa" indicated an infection and that Aids may be a result thereof.

(c) He denied that he stated that the account had nothing to do with Aids and that he would follow it up with Drs Buisson and Partners.

(d) He denied that her water broke on 2 April but stated that he caused it to break in an attempt to get the patient to go into normal labour. He refers to the hospital report which indicates that the membrane was intact. He states that when he broke the water there was a very offensive discharge. It seems as if, after the Caesarian Section, he formed the opinion that it was the result of an intra uterine infection which may have caused the stillbirth.

(e) He denied that he asked to see her husband and says that after he had informed her of her status he asked her whether she would tell her husband or whether he was to do it. He says that she asked him to do it and that he subsequently did so.

(f) He denied that he had told the complainant that the baby was also HIV positive. He denied that he performed any HIV testing on the baby. What he told her was that its death was probably caused by its mother's HIV status and intra uterine infection. He explained that the reference to HIV on the death certificate was a reference to the mother's HIV status.

(g) He explained that he considered it to be heartless and cruel to inform a woman pregnant with her first child one month before its birth that she was HIV positive. At that stage such information could not change anything. In any event statistics show that only one half of children born HIV negative convert to HIV positive.

(h) He pointed out that there were no facilities for pre- or post natal test counselling at the Louis Trichardt hospital. Nor did there exist protocols regarding measures to reduce the risk of mother to child transmission.

(i) He also denied that there was any risk of mother to child transmission.

In a letter dated 14 April 2000 the appellant's attorney was informed that the Committee of Preliminary Inquiry of the first respondent had found that there had been no improper or disgraceful conduct on the part of the third respondent. At the request of the appellant's attorney the reasons for the finding were supplied in a letter dated 21 February 2001. The reasons read as follows:

"I refer to your letter dated 28 November 2000 and wish to advise that the Committee (sic) to accept the respondent's explanation was based on the following facts:

1. The acceptance that the patient was informed of the HIV testing and that she consented to it.
2. That there is a lack of facilities for proper pre- and post HIV testing in the hospital.
3. Noted that the patient's husband was only informed at the request of his wife (the patient).

It was on the strength of these facts and other factors as outlined in Dr Labuschagne's letter to Council dated 27 August 2000 that his explanation to the allegations against him was accepted.

In the application, which was launched on 31 October 2001, the appellant reiterated the facts stated in her letter of complaint with the exception that she conceded that her husband had been informed of her HIV status with her consent. Her husband was subsequently tested for HIV and the test was negative. These circumstances led to a separation between her and her husband. She denied that there were no facilities for pre and postnatal counselling at Louis Trichardt. Such facilities were available at the government primary health clinic.

It was contended for the plaintiff in the heads of argument that-

1.1.1. the HPC is under a statutory duty to act on complaints of improper or disgraceful conduct if a *prima facie* case of such conduct is established;

1.1.2. the common cause facts point overwhelmingly to a serious transgression of the ethical obligations by which Dr Labuschagne was bound;

1.1.3. the HPC failed to appreciate the nature of its obligations and accordingly did not exercise a proper discretion;

1.1.4. Daniels J [in the court *a quo*] wrongly concluded that the difference between consent and informed consent was marginal. Moreover, in finding that Dr Labuschagne acted in what he believed to be the best interests of his patient, Daniels J confused the inquiry into improper conduct with the inquiry into mitigation. Finally, while Daniels J implicitly found that Dr Labuschagne had breached the guidelines for the management of patients with HIV, he relegated the breach to a matter of no consequence, holding that the guidelines were not cast in stone. In so holding, he constructed a defence not even advanced by Dr Labuschagne himself, nor one even alluded to by the Committee or the HPC. On the contrary, both the HPC and the Committee considered the guidelines as binding on all doctors. It was accordingly submitted that Daniels J erred in dismissing the application.

The main grounds on which the appellant relied were-

(a) that the second respondent misdirected itself in accepting the version of the third respondent regarding the question of whether she had consented to HIV testing in spite of the existence of a dispute of fact.

(b) that the second respondent ignored the fact that on the version of the third respondent he had not obtained her informed consent.

(c) that the second respondent erroneously accepted that there "was a lack of facilities for proper pre- and post-HIV testing in the hospital".

The Committee of Preliminary Enquiry of the HPCSA had declined to refer the complaint to a disciplinary committee and found that the doctor had not acted improperly or disgracefully despite the fact that there was a dispute of fact between the doctor and the patient which could only be resolved by means of an inquiry.

In its judgment, the appeal court observed that the court *a quo* pointed out that there was a dispute about the existence of counselling facilities at the hospital which the appellant did nothing to dispel in spite of being afforded the opportunity to do so. It found that the respondent's version in this regard was more probable. In respect of the first and second respondents' acceptance of the third respondent's explanation, it

posed the question whether it was so unreasonable as to warrant interference by the court. It made the observation that the consent obtained by the third respondent from the appellant probably did not qualify as informed consent in terms of the guidelines. It remarked that the difference between consent and informed consent is marginal and that it was of no real moment that the appellant was only informed of the outcome of the HIV test at a later stage. It described the approach of the third respondent as one that displayed compassion and concern. Nothing would have changed if the appellant had been told of the test result earlier. It came to the conclusion that the conduct of the third respondent did not amount to improper or disgraceful conduct. To the extent that the third respondent had deviated from the guidelines the court accepted a submission that the guidelines were not cast in stone. With reference to a submission based on *Veriava and others v President, South African Medical and Dental Council and others*[289] that there was a *prima facie* complaint that called for an inquiry, it found that the complaint was a mere allegation and had not been substantiated.

Counsel for the appellant, argued that the first respondent was under a statutory duty to act on complaints of improper or disgraceful conduct if a *prima facie* case of such conduct had been disclosed. He contended that in this regard the first respondent failed to appreciate its statutory duties. He referred to section 15 A(g) and (h) and section 41 of the Health Professions Act[290] (the Act) and to the case of *Veriava supra.* He submitted that the finding in *Korf v Health Professions Council of South Africa*[291] that the first respondent was not an organ of State must be considered to have been wrongly decided in the light of the decisions of the Constitutional Court in cases, like *National Gambling Board v Premier, KwaZulu Natal and Others*[292], *Independent Electoral Commission v Langeberg Municipality*[293] and *Islamic Unity Convention v Independent Broadcasting Authority and Others*[294]. Then he argued that even the undisputed facts disclosed a *prima facie* case of improper and disgraceful conduct in that the third respondent had failed to obtain the appellant's informed consent, that he had failed to conduct pre and post test counselling, or had failed to refer the appellant for such counselling and that he had failed to counsel the appellant on the prevention

289 *Veriava* 1985 (2) SA 293 (T)
290 Health Professions Act 56 of 1974
291 *Korf* 2000 (1) SA 1171 (T) at 1178 D
292 *National Gambling Board v Premier, KwaZulu Natal and Others* 2002 (2) SA 715 (CC)
293 *Langeberg Municipality* 2001 (3) SA 925 (CC)
294 *Islamic Unity Convention* 2002 (4) SA 294 (CC)

of mother to child transmission of HIV. In respect of informed consent he referred the court to *Castell v De Greef*[295] and *C v Minister of Correctional Services*[296].

Counsel for the first and second respondents, conceded that the first respondent was an organ of state as defined in section 23 of the Constitution of the Republic of South Africa. He argued that the second respondent furnished sufficient reasons for its decision and that a court would not lightly interfere with the decision. The second respondent accepted the third respondent's explanation and there was a rational connection between the decision and the facts on which it was based. He referred to the regulations governing the matter and pointed out that the regulations published in Government Notice R2303 of 29 September 1990 were applicable. In particular he referred to regulation 7 which entitled Committee of Preliminary Inquiry not to direct an enquiry if a complaint, even if substantiated, does not constitute improper or disgraceful conduct. With reliance on the case of *Veriava supra* he submitted that the correct test was not whether disputes of fact existed, but whether *prima facie* evidence of improper or disgraceful conduct had been presented. He pointed out that the Committee of Preliminary Inquiry was a peer committee and submitted that it, having regard to the complaint and the explanation, had found that there was no *prima facie* case against the third respondent. To the extent that the third respondent deviated from the guidelines, he submitted that they were not intended to be followed slavishly. He pointed out that the Promotion of Administrative Justice Act[297] had not come into effect when the second respondent's decision was taken and that the matter had to be decided in terms of section 33 (1) of the Constitution. He submitted that the court should be slow to substitute its opinion regarding the propriety of professional conduct for that of an expert body. In this regard he referred to *Thuketana v Health Professions Council of South Africa* [298].

Judgment

The full court noted that where there is a fundamental dispute of fact the Committee of Preliminary Inquiry of the HPCSA has no means of resolving it. It finds itself in

295 *Castell* fn 98 *supra* at 425 H – I
296 *C v Minister Correctional Services* 1996 (4) SA 292 (T) at 300 G – J.
297 Act 3 of 2000
298 *Thukehana* [2002] 4 ALL SA 493 at 504 E – 505 C

much the same position as a court confronted with a dispute of fact in motion proceedings. If the complaint, on the face of it, discloses improper conduct, the only way of resolving the dispute of fact is to direct an inquiry. The court found that there was a fundamental dispute about whether the third respondent had informed the appellant that the blood taken from her would be tested for HIV. It was never suggested that it would have been proper for the third respondent to have taken the appellant's blood for that purpose without informing her of the purpose of the test. If such a view had been tenable, it would have been possible for the second respondent to decline to direct an inquiry with reliance on regulation 7. It held that it was clear therefore that the second respondent on a vital dispute of fact accepted the third respondent's version and rejected that of the appellant. In doing that it misconceived its powers and overstepped the bounds of its discretion. For that reason its decision should be reviewed and set aside.

It was argued that if it was not competent for the second respondent to decide the factual dispute about consent, the matter should be referred back to it so that it could reconsider the matter. Technically, said the court, it was correct that it was still open for the second respondent to consider the complaint for the purposes of regulation 7, that is to establish whether the complaint, even if substantiated, did not disclose improper conduct. It was also true, said the court, that the second respondent is peculiarly equipped to make such an assessment. In the circumstances of the case, however, the court found that it would not be appropriate to follow such a course. It stated that if the second respondent had been of the view that the complaint, even if substantiated, did not disclose evidence of misconduct, it could have declined to direct an inquiry in the first place on that ground. Then there was the dispute about whether the third respondent had told the appellant about the purpose of the test. The court stated that it seemed inevitable that that dispute should be resolved and it could only be resolved by means of an inquiry.

The court held that in the circumstances, the appeal should succeed and that relief should be granted in terms of paragraph 2 and 3 of the notion of motion. In view of this conclusion it held that it was unnecessary and also inadvisable, for the court to make any pronouncement on all the arguments to the effect that on the undisputed facts the third respondent was in any event guilty of improper or disgraceful conduct.

Discussion

This case is of interest because it involves the failure of a health professional to disclose information to a patient as much as it does a lack of informed consent to an HIV test. Although so-called therapeutic privilege was not expressly raised as a defence, Dr Labuschagene did state in his response to the plaintiff's complaint that it seemed cruel to disclose her HIV positive status to a woman pregnant with her first child one month before it is due to be born. Dr Labuschagne had something of a dilemma when the HIV tests result turned out to be positive because he had not obtained the patient's informed consent to have the test done in the first place. The question is whether there is an obligation upon a health professional to divulge the results of all tests conducted upon the patient or whether he or she is legally entitled to withhold some of this information. Therapeutic privilege and informed consent are intricately intertwined in the provider-patient relationship. If the patient is not sufficiently apprised of the risks of an intervention then the consent falls short of being informed and the provider could be liable in delict. The capacity of an adult patient of sound mind patient to understand, assess and accept medical risk is wholly dependent upon the extent to which he or she is informed of those risks. If, on the other hand, the patient has the metaphorical 'thin skull' and is unable for some reason to cope psychologically with the information that is disclosed, there is the risk of a claim in delict for damages for emotional shock.

The Promotion of Access to Information Act[299] acknowledges that it may not always be appropriate to disclose certain information to a patient where the effect of that information may adversely affect that patient's health or wellbeing. It is submitted that this is tantamount to statutory recognition of a kind of therapeutic privilege. The relevant sections of the Act, sections 30(1) and 61(1), provide that where the person in charge of a public or private body is of the opinion that the disclosure of the record to the relevant person might cause serious harm to his or her physical or mental health, or well-being, the head may, before giving access in terms of section 60, consult with a health practitioner who, subject to subsection (2), has been nominated by the

299 Act No 2 of 2000

relevant person. If, after being given access to the record concerned, the health practitioner consulted in terms of subsection (1) is of the opinion that the disclosure of the record to the relevant person, would be likely to cause serious harm to his or her physical or mental health, or well-being, the head may only give access to the record if the requester proves to the satisfaction of the head that adequate provision is made for such counselling or arrangements as are reasonably practicable before, during or after the disclosure of the record to limit, alleviate or avoid such harm to the relevant person. Presumably, if no such proof is supplied, or proof which is not satisfactory is supplied, access to the record may be withheld.

It is submitted that the recognition in the South African law of delict of the possibility of damages for emotional shock is supportive of the concept of therapeutic privilege. After all one cannot on the one hand recognise that the negligent disclosure of distressing information can cause harm in the context of the law of delict and fail to recognise this same principle in the context of health service delivery. A case in point is *Clinton-Parker v Administrator, Transvaal Dawkins v Administrator, Transvaal* [300] in which the court awarded damages for emotional shock to two couples who had discovered that their babies had been swapped after they were born. The plaintiffs discovered the swop some 18 months after they gave birth. The plaintiffs decided to keep the children handed to them by the hospital. They are suing the defendant for damages flowing from the swop. It was common cause that the plaintiffs had suffered severe psychological damage for which they would require treatment in consequence of the swop. Navsa J observed that it was common cause that the fact of the negligent swopping of their children at birth, and the communication thereof some 21 months thereafter, caused the plaintiffs to suffer a psychiatric disorder, viz a mixed anxiety depressive disorder. He noted that the defendant's counsel in their heads of argument acknowledged that *Bester v Commercial Union Versekeringsmaatskappy van SA Bpk*[301] "contains the fullest and most recent exposition in our law of the applicable

300 *Clinton-Parker* fn 225 *supra*

301 *Bester* 1973 (1) SA 769 (A). In Bester's case liability was disputed on the basis that the injury suffered was shock of a psychiatric nature and was not a physical injury. Botha JA, in dealing with this argument, said the following: "So 'n betoog is uit die aard van die saak vreemd aan die beginsels van ons reg, en ietwat gekunsteld in die lig van die feit dat volgens die Romeins-Hollandse reg aquiliese aanspreeklikheid sodanig uitgebrei is dat vergoeding met die actio in factum verhaal kan word van enige skade wat op onregmatige en skuldige wyse veroorsaak is. (*Matthews and Others v Young* 1922 AD 492 op 504.)" The learned Judge of Appeal then went on to state 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

principles in regard to claims of this nature". Counsel were referring to claims for damages where a plaintiff claims that he/she has suffered emotional shock or psychiatric injury as a result of the negligence of a defendant. Navsa J after examining South African and foreign precedent on the subject concluded that there was reason in principle or policy why the plaintiffs should not succeed in their claims. In his view, the harm suffered by the plaintiffs was sufficiently close to the defendant's negligence for liability on the defendant's part to arise. There are other cases in South African law which also recognise the possibility of damages for emotional shock[302].

It is submitted that it is therefore technically possible for a health professional who negligently discloses distressing information to a patient who to his knowledge is unlikely to be able to cope with the disclosure and who suffers emotional shock as a result of the disclosure to be liable for damages in delict. Naturally there would have to be a balancing exercise in considering claims of this nature. Strauss[303] observes that jurist's rigid insistence in the past upon informed consent has in recent years made room for a more realistic approach and that today it is realised that to insist that the patient be fully informed at all times is not always in his interest. He quotes an Israeli judge, J Türkel as stating bluntly that "in the majority of cases, it is our duty to lie to the terminal cancer patient...In principle I cannot see any difference between the giving of an analgesic drug, or other drugs to such a patient and the giving of a drug named illusion". With respect to that learned judge in that case, the present writer can see a significant difference between these two scenarios which in a phrase is the right to self-determination. An informed patient has a choice as to whether or not to take pain-killing drugs which will hasten his or her death. The same does not apply to a patient who is denied the knowledge of his or her condition. Whilst there may well be cases in which it is in the patient's best interest not to inform him of his condition, the circumstances of each case must be considered on its merits. The present writer is of the view that patients are in any event not nearly as ignorant as some providers may believe and that in many instances they are likely to be aware that something could be

---

victim compensation purely on the basis that the shock and consequential harm were not allied to a physical injury cannot be defended logically. As support for this conclusion the learned Judge referred, *inter alia*, to the case of *Waring & Gillow Ltd v Sherborne* 1904 TS 340, where a plaintiff sued for damages for shock flowing from a report of the death of her husband; the death having been caused by a negligent act. With reference to a dictum of Innes CJ at 348 of that case, the learned Judge concludes that it is clear that the claim was rejected because of the remoteness or the unforeseeability of the harm caused. (Note: excerpted from judgment in *Clinton-Parker*)

302 See for instance *Hauman v Malmesbury Divisional Council* 1916 CPD 216; *Barnard v Santam Bank Bpk* 1997 (4) SA 1032 (T); *Road Accident Fund v Sauls* 2002 (2) SA 55 (SCA)

303 Strauss fn 29 *supra* at p18

seriously wrong. Therapeutic privilege should only be exercised in that narrow set of circumstances in which the patient is likely to be more harmed than helped by the disclosure. It should not be used as a general excuse not to give a patient from bad news. The decision of the court in *VRM* appears indirectly to endorse this view. If the patient in this case had been informed of her HIV positive status at the time when it was diagnosed, a number of options may have been open to her. She could have elected to terminate the pregnancy (although this may not have been a real option so late in the term) or to continue with the pregnancy and take measures to prevent mother-to-child transmission of the disease. She could have gone for counselling as to the implications of her condition for both herself and the child she carried and perhaps have been better prepared for the possibility that the baby could be stillborn. Instead, her life fell apart on the day that her child was born dead, she was told in an apparently callous an unfeeling manner of her HIV positive status and her husband was also informed of that status. Presumably he did not receive the news well given the fact that he subsequently tested negative for HIV and that by the time the case came to court, the couple were already separated.

Having said this, there are circumstances in which it is submitted that therapeutic privilege even in its wider sense may have a significant role to play. An example is the case of a minor who has been sexually abused by parents or other family members in whose custody they find themselves. The irony of the situation is that the very person who has care and custody of a child and who is therefore ordinarily responsible for giving informed consent to health care services on his or her behalf is the one who is abusing the child. It is submitted that in such circumstances it may at times be useful for a provider to be able invoke therapeutic privilege in communicating with the child's parent or guardian as to the nature of his or her condition. One of the worst case scenarios is where a minor is pregnant with the child of a parent or other relative and, but for the provisions of the Choice on Termination of Pregnancy Act[304], would have required the consent of that same parent or relative to

---

304 Act No 92 of 196. Section 5 provides that –
(1) Subject to the provisions of subsections (4) and (5), the termination of a pregnancy may only take place with the informed consent of the pregnant woman.
(2) Notwithstanding any other law or the common law, but subject to the provisions of subsections (4) and (5), no consent other than that of the pregnant woman shall be required for the termination of a pregnancy.
(3) In the case of a pregnant minor, a medical practitioner or a registered midwife, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated:

terminate the pregnancy. The Act does not obviate the need to be able to invoke therapeutic privilege against a parent or guardian in order to protect the health or wellbeing of a minor since it applies only in the context of terminations of pregnancy. A similar situation would be a case of elder abuse in which an elderly person is suspected of being abused by a caregiver who has brought that elderly person for medical attention. A further example is that of intersexuality in children[305].

Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them."

In section 1 of the Act a woman is defined as "any female person of any age"

305 Côté A, 'Telling the Truth? Disclosure, Therapeutic Privilege and Intersexuality in Children' *Health Law Journal* Vol 8, 2000 p199 notes that family physicians, paediatricians and geneticists meet a variety of young patients at various stages of the maturing process. As clinicians are privy to information about their patients that may be disturbing, they develop knowledge about human nature and decide, often along with parents, the appropriate level of information for different children and adolescents. She states that while it may be possible in a clinical sense to delineate the differing ages of understanding of a particular patient, the law may not always recognised these incremental changes. The law insists, with few exceptions, that those capable of consenting to treatment deserve the disclosure of appropriate information. After considering the legal and ethical principles of informed consent she goes on to consider therapeutic privilege, its nature and limitations. She notes that if a physician feels that disclosure of certain information will lead to the harm or suffering of the patient, she or he is said to be free to withhold this information. She states that information can be withheld if it is counter therapeutic, dysfunctional or distorting for the particular patient in question. This doctrine is traced back to the American case of *Canterbury v Spence* 464 F. 2d 772 (d. C. Cir 1972) where it is declared that if information is 'menacing' to a patient it need not be disclosed. She points out that the exception is raised were 'a direct conflict…arises between the doctor's medico-ethical duty to health and his legal-ethical duty to inform." This is based on the assumption that the physician cares not only for the patient's physiological health but for his psychological and moral well-being as well. Côté notes that while the therapeutic privilege has been termed 'an American exception' by one Canadian court, its existence north of the border has nevertheless been alluded to by the Supreme Court of Canada. In *Reibl v Hughes*, [(1980) 114 D.L.R (3d) 1 (S.C.C.)] Laskin C.J. C. states that 'it may be the case that a particular patient may, because of emotional factors, be unable to cope with facts relevant to recommend surgery or treatment and the doctor may, in such a case, be justified in withholding or generalizing information as to which he would otherwise be required to be more specific.' In response to this, she notes, Maloney J, in *Meyer Estate v Rogers* [(1991) 78 D.L.R. (4th) 307 (Ont. Gen. Div.) at 312] has nevertheless declared that the therapeutic privilege has no place in Canadian law. The following year, the Supreme Court of Canada in *McInerney v MacDonald* [(1992) 93 D.L.R. (4th) 415 (s.C.C.)] at 427 again stated that information can be withheld from a patient of it is not in the patient's best interest to receive it. However, the Ontario Court of Appeal has held that the exception does not apply in the case of elective surgery. (*Videto v Kennedy* (1981) 125 D.L.R (3d) 127). Côté observes that this limit may not apply in Alberta where the therapeutic privilege exception has been codified in the Health Information Act which provides that –

11(1) A custodian may refuse to disclose health information to an applicant

(a) if the disclosure could reasonably be expected

(i) to result in immediate and grave harm to the applicant's mental or physical health or safety.

Therefore, she says, while many commentators have called for its elimination the therapeutical privilege remains part of Canadian law. It is worth noting that Ackermann J followed the judgment in *Reibl v Hughes* in *Castell v de Greef* in the judgment that established the doctrine of informed consent in South African law.

Van Oosten FFW "The So-called Therapeutic Privilege' or Contra-Indication': Its Nature and Role in Non-Disclosure Cases" (1991) 10 Med. & L. 31describes six instances where disclosure is restricted:

(a) where disclosure would endanger the patient's life or affect physical or mental health;
(b) where disclosure might prevent rational decision-making because the information is confusing or frightening
(c) where disclosure causes such anxiety and distress that it might jeopardise the outcome of the intervention
(d) where the patient is moribund and disclosure would be inhuman
(e) where the risks of disclosure are as much as or more serious than that of intervention
(f) where disclosure would seriously prejudice third parties.

Côté points out that excluding the final category the first five explore only the severity or source of harm to the patient. However, she says, without a definition of 'serious', even a detailed list such as this one leaves much to the discretion of the physician. What is certain, says Côté, is that the harm cannot be merely trivial, nor can the 'harm' be that a patient may refuse beneficial treatment if informed. The therapeutic privilege must not be invoked because the patient will make an 'inappropriate' choice. She states that it is clear that both ethically and in Canadian jurisprudence individuals are permitted to make 'wrong' or 'bad' choices. If this were not the case then there would be no need for informed consent at all for the doctor's reasonable medical decisions could be held to stand in for those of the patient or the patient could merely be handed a list of preclassified 'reasonable' alternatives from which to choose. She notes that this scenario would obviously make a mockery of the idea of respect for persons and for bodily integrity. According to Côté, there is also a concern that the therapeutic privilege exception will be overused because physicians are anxious to avoid dealing with patients who become upset. She points out that sensitive disclosure can actually help a patient and prevent psychological harm by allaying fears that are exaggerated. Of particular interest to a consideration of the judgment in VRM is her observation that what is not directly addressed in the literature or case law is the issue of whether or not a diagnosis, as opposed to the risks of procedure, can be withheld from a patient because it is feared that its disclosure will cause harm. Côté comments that physicians may rely on the fact that they need not disclose to children or adolescents diagnoses about their genetic or biological sex status because this information would be terribly upsetting to the child.

The National Health Act partially codifies therapeutic privilege. Section 6(1) stipulates that every health care provider must inform a user of-

"(a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;

(b) the range of diagnostic procedures and treatment options generally available to the user;

(c) the benefits, risks, costs and consequences generally associated with each option; and

(d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal."

It is submitted that this codification is only partial because it is questionable whether, the wording of section 6(1) and the reference to health status includes therapeutic privilege with regard to medical procedures. The wording seems only to recognize therapeutic privilege when it comes to diagnosis or the state of health of the patient. The exception is contained in section 6(1)(a) and therefore does not apply to paragraphs (b) to (d) of subsection (1).

There is a further recognition of therapeutic privilege implicit in section 8(3) of the Act which states that: "If a user is unable to participate in a decision affecting his or her personal health and treatment, he or she must be informed as contemplated in section 6 after the provision of the health service in question unless the disclosure of

---

She observes that on the one hand it is arguable that a patient is at least likely to become upset at this type of information as hearing about a proposed treatment. On the other hand, she says, this is precisely the sort of information for which a patient goes to a physician. One would have to imagine a situation where the diagnosis itself would cause harm to the child (for instance in the case of a suicidal child). However, if the physician relies on a pre-existing mental condition to invoke the privilege, she or he confuses the use of the exception with the doctrine of incapacity. This confusion may cause the overuse and misapplication of the exception. She states that to apply the exception to the withholding of a diagnosis, there needs to be a clear indication that the child will be seriously harmed by the provision of the diagnosis itself (not by a pre-existing condition that would lead to a finding of incapacity). Côté notes that in order to ensure that the exception of therapeutic privilege is not misused by overzealous physicians, there are a number of limitations placed on it. The first of these is that the burden of proof (a "heavy" burden) rests on the doctor. The latter must show that the non-disclosure was in the best interest of the patient. It submitted that is highly likely that a similar burden or proof will also rest on a South African health professional in the light of the provisions of section 6(1)(a) of the National Health Bill. Another limitation she identifies is that merely because information disclosed *in toto* may be upsetting, this does not preclude *all* disclosure. Not only must the clinician assess whether or not there may be less upsetting ways of disclosing the information, it may be presented in a way that is more generalized than for the average patient. Côté notes that this may be particularly useful when dealing with children and adolescents. Another limitation on the exception is that it may be required (and most certainly would be required in the case of children) that if the exception were invoked, the disclosure must be made to a close relative (most likely parents or guardians in the case of children and adolescents). She says that this disclosure to a relative first ought to be made in order to assess whether the disclosure would in fact be harmful to the child and whether there might be a way to minimize this harm. Therefore parents themselves may be asked to tell children of the genetic or biological sexual abnormality (and any ensuing treatment) in age-appropriate language.

such information would be contrary to the user's best interest." This section deals with a situation where due to the severity or nature of his illness a patient was unable to give informed consent to treatment or to participate in a decision as to treatment before receiving it. The section imposes a legal requirement that such person is informed as contemplated in section 6 after having received the treatment. The therapeutic privilege exception is clearly contained in the latter half of section 8(3).

In terms of section 7(3) of the National Health Act the exception of therapeutic privilege is incorporated by reference into the doctrine of informed consent as contained in section 6 of the Act. It states that "For the purposes of this section "informed consent" means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6." Thus where a person has not been informed of their health status because of the exception in section 6(1)(a) but the other criteria in section 6 have been observed, this constitutes informed consent for the purposes of the Act.

It is submitted that the provision for therapeutic privilege in the Bill does not necessarily eliminate the legal dangers of using it. If anything, the Bill reinforces the view of Strauss referred to below that the exception should only be used in circumstances where there is clear and well established evidence of the patient's sensitivity. The phrase 'substantial evidence' it is submitted, is not to be taken lightly in view of the constitutional rights of the patient.

It is submitted that one must balance the merits of exercising therapeutic privilege against the value of pre-disclosure or pre-treatment counselling such as is contemplated in both the Promotion of Access to Information Act and the Choice On Termination of Pregnancy Act. It is submitted that in view of the importance of patient autonomy, the constitutional rights to human dignity, freedom and security of the person and bodily and psychological integrity, (as well as South Africa's unfortunate history of human rights abuses to which the medical profession was in some instances a party[306]), pre- and post-event counselling should be explored

306 And for which the then Medical Association of South Africa (which was subsequently transformed into the South African Medical Association) publicly and unreservedly apologised in a resolution adopted in June 1995 (See address by the Deputy President T M Mbeki at the opening of the 48th General Assembly of the World Medical Association http://www.anc.org.za/andocs/history/mbeki/1996/sp961025.html; Williams J R 'Ethics and Human Rights In South

wherever possible as an alternative to a situation in which it is anticipated there may be a need to exercise therapeutic privilege. The repeated references of Ackermann J in *Castell v de Greef*[307] to *so-called* therapeutic privilege also suggest caution in exercising such 'privilege'. It is probably better phrased as 'therapeutic non-disclosure' than therapeutic privilege in view of the legal liabilities that could attach to the non-disclosure of information to a patient. Strauss, writing well before the passing of the National Health Act, notes that the parameters of therapeutic privilege are as yet undefined in American law[308]. He states that in fact so far it is perhaps no more than a theme running through minority decisions and there is some indication that American juries may not be so quick to accept it as a defence. Strauss observes that a doctor would be well-advised not to rely on this defence unless it is clearly documented that the patient's sensitivity was well above the norm[309].

9.3 Summary and Conclusions

More detailed conclusions and observations on particular points of law have been made in the preceding pages and will not therefore be repeated here. The observations and conclusions that follow are of a more general nature.

The law of delict is undoubtedly a dynamic and living subject in which not even the basic elements seem certain at present. Whilst this is somewhat disturbing, and it is submitted that there is cause for concern as to the quality of the latest decisions emerging from South African courts, it may be symptomatic of a period in which many long established legal principles of law are being challenged or rethought in the

---

African Medicine' *Canadian Medical Association Journal* 2000; 162(8): 1167-70; Human Rights and Health: The Legacy of Apartheid http://shr.aaas.org/loa/sector.htm ; and the report of the Truth and Reconciliation Commission in the chapter on the health sector)

307 *Castell* fn 123 *supra*

308 Dinnie D 'Consent and Therapeutic Privilege' http://www.deneysreitz.co.za/news/ notes the same with regard to South African law in his discussion of *VRM* in saying that the court did not define the ambit of therapeutic privilege.

309 See Strauss (fn 29 *supra*) at pp18 to 19 and the authorities there cited. See also Coetzee LC 'Medical Therapeutic Privilege' (unpublished Master dissertation University of South Africa, 2001). He points out that beneficence has been a guding principle in medical practice for a very long time but that a growing acknowledgement of the importance of truth-telling as an ethical principle has given rise to tension. This tension acquired legal significance with the advent of the doctor's duty to inform and the doctrine of informed consent. Coetzee states that recognition of the therapeutic privilege implies that a patient's decision may lawfully be substituted by the doctor's 'objective' decision. The problem is that the doctor more often than not lacks the necessary knowledge of the patient's non-medical needs to be able to make an objective decision. He notes that evidence is mounting that the medical assumption underlying therapeutic privilege is false. He recommends that the emphasis should be shifted from "what to tell the patient" to "how to tell the patient" and "when to tell the patient" and that improving the quality of communication skills could go a long way to overcoming the problem of avoiding harm through disclosure.

light of the relatively new constitutional legal dispensation that has yet to settle into the furthest reaches of the South African legal system. Whilst the concerns around fuzziness of elements of the law of delict and the importance of legal certainty should not be downplayed, it is worth noting that the flexibility or fuzziness around the element of unlawfulness, based as it is on the *boni mo*res, has been lauded by more than one academic writer and seems generally to have served the legal system well since it was so incisively described by Rumpff CJ in *Minister van Polisie v Ewels*[310].

There is, however, much room for improvement in the law of delict in its application within the health care context in particular. The most obvious is the need for the courts to revisit their refusal to allow the application of the *res ipsa loquitur* to matters medical.

Without detracting from the importance of the principle of *stare decisis*, one must not forget that the courts do have the power to depart from established principle where it is clearly wrong, something which the doctoral thesis of P van den Heever has hopefully demonstrated with regard to *van Wyk v Lewis*[311] and the applicability of the *res ipsa loquitur* maxim in the context of the delivery of health services. There is a general need to recognise the imbalance of power between the patient and the provider in individual cases and to factor this into decisions concerning wrongfulness and legal causation. Health care services and products are not just another commodity. They have been compared to food by those who argue in favour of a trade based perception of health care transactions but it is submitted that there are significant differences between food on the one hand and health care products and services on the other. These are –

- The production of food is not subject to a licence from a government authority. Unlike most medicines, food can be grown in one's own backyard;
- Accessibility to food is not governed by the need for a prescription from an expert;
- The production and supply of food does not require years of specialised training and expertise;

310 *Ewels* fn 66 *supra*
311 *Van Wyk* fn 3 *supra*

- Whilst it is true that without food the body will die, the environment in which both are required is such that food as a less complex product is generally far more accessible than medicine and in all but the most extreme and unfortunate cases, it is more readily available in terms of factors such as cost and distribution.
- Anyone can supply someone who is hungry with food. The same certainly is not true of health care products and services.
- The level and degree of research that goes into the production of food, whilst it can be significant and intense, is not nearly comparable with that which goes into the production of medicines and health care equipment.
- People are able to significantly adapt their diets, if need be, to their socio-economic circumstances in the sense that, while the food they eat may not be ideal it is enough to keep body and soul together. In the case of medicines and health care services there is no comparable option to adapt.
- Most people have a much greater understanding and appreciation of processes of food production and application than they do medicines.
- Most foods, unlike most medicines, are not poisonous substances.

The tendency of the courts to prefer to decide cases on the basis of the law of delict when faced with claims in both contract and delict, despite the fact that it has been observed that the basis for the delivery of health care services is mostly contractual, is quite possibly indicative of a feeling or belief that the delivery of health care services is more than just business as usual. In the context of the law of delict the legal convictions of the community are brought into play in matters of this nature and the obligations of the provider to the patient must be seen in a larger context than just the narrow terms of a contractual relationship in which there is very clearly the balance of power still favours providers over patients. This said, however, the difference between the law of contract and the law of delict is becoming notional and if the courts could bring themselves to apply the law of contract within the broader context of contstitutional rights and principles and at the same time acknowledging the way the world is now, the law of contract still has a useful role to play in the context of health service delivery.

The convergence between the law of contract and of delict is encouraging in the sense that the same constitutional values and principles should underpin them both and that decisions should be consistent across different fields of law as well as within them if the constitutional order is to prevail. It must be stressed however that each of them is a logical system in its own right and, whilst one should never prize legal principles over justice, this should not be seen as a mere technical nuisance by the courts but rather as the basis of logic and experience that ultimately ensures that the end result is, in fact, justice.